New Hampshire Family First Title IV-E Prevention Plan

June 2, 2021

Division for Children, Youth and Families
Department of Health and Human Services

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Section 1: Introduction

The Family First Prevention Services Act (FFPSA) provides an unprecedented opportunity for transformation in New Hampshire as we work toward a vision where all children are safe, and families thrive. Submitting this Title IV-E Prevention Plan is New Hampshire's opportunity to continue to leverage all available resources to realize and sustain this vision. In partnership with community service providers, sister divisions, and local stakeholders, the New Hampshire Division for Children, Youth, & Families (DCYF) will build cohesive community supports and resources through Family First and its greater prevention strategy to help each child realize their potential and safeguard vulnerable families. In doing so, New Hampshire will leverage this opportunity to:

- Keep families together by providing high-quality prevention services for in-home DCYF cases.
- Reduce entries/re-entries into foster care by providing services to high-risk families in the community who have come in contact with DCYF.
- Keep families from becoming further involved with DCYF by providing prevention services to high-risk groups the first time they come into contact with Child Protective Services.

Overview of Jurisdictional Considerations Related to Family First and its Overall Prevention Strategy

The provisions of the Family First Prevention Services Act (Family First) aligns to DCYF's current focus on strengthening partnerships with other public and private stakeholders and building out a continuum of care to provide the right service to the right children, youth, and families at the right time to prevent further involvement with DCYF as outlined in DCYF's core strategic priorities for 2020-2021 (New Hampshire Department of Health and Human Services NH DCYF Strategic Priorities, 2020c). With the support of federal claiming through Family First, DCYF plans to elevate and expand home-and community-based services designed to address the needs of several at risk populations across the child-and family-serving system. These community-based services are intended to safely keep families together to prevent unnecessary entries into out-of-home care, sustain family reunification, as well as support successful transitions into adulthood for involved youth.

The enhanced service array will support parenting knowledge and skill building, child mental health and substance use needs, as well as ensure families are linked to more concrete supports and resources. In doing so, DCYF intends to build on and expand parts of the Division's service system that are already effective, while partnering with other Department of Health and Human

Services (DHHS) divisions to make additional enhancements. The following section outlines several recent and important initiatives that highlight how New Hampshire's prevention efforts will impact the implementation of Family First.

Recent Expansion of Community-Based Prevention

The timing for the introduction of Family First in New Hampshire is particularly notable given that it will coincide with the launch of a new prevention program known as the Community-Based Voluntary Service (CBVS) model in early 2021. With the support of the Governor and the New Hampshire legislature, DCYF has substantially expanded its ability to offer prevention programs to more families who are at risk for child welfare involvement through CBVS. The model will serve families identified as being safe and high risk or very high risk through DCYF's standardized, actuarial safety and risk assessment tools and appropriate for community-based case management services and other direct services at the time of investigation.

Prior to the reintroduction of voluntary services by the legislature in SFY2018 – DCYF did not have a funded voluntary service program. The only means by which DCYF could provide ongoing case management and home-based services to families after an investigation was if they received a legal finding of child abuse or neglect or the Director authorized funding for services. However, due to the relatively stringent legal requirements necessary to substantiate an allegation of child abuse and neglect in New Hampshire and the lack of available funding, many families who were at risk of future maltreatment had their investigation closed without findings and did not receive ongoing services. As a result, families often needed to experience another crisis to re-enter the DCYF system to receive services.

Due to legislative efforts to re-establish funding, the CBVS program now seeks to fill this gap by enabling DCYF to significantly expand the number of families who can be served and supported in a collaborative community setting. During initial rollout, DCYF estimates that approximately 2,000 families will be eligible for CBVS referral. Further discussion on the CBVS population will follow in section 2.

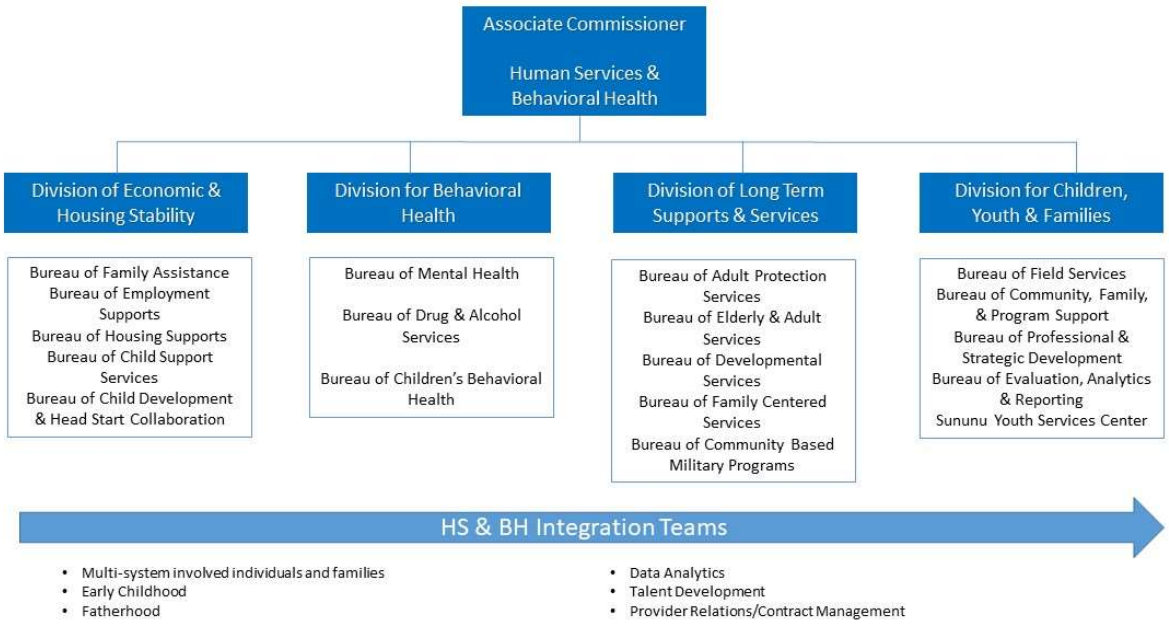
Infrastructure Enhancements across DHHS

The implementation of Family First in New Hampshire will be benefited by an infrastructure that singularly houses a vast array of public services, including the Division for Children, Youth and Families, under the Department of Health and Human Services (DHHS). The Department's purview includes services related to mental health, developmental disability, substance abuse, child protection, housing, entitlements, child development, and public health. Following the release of an independent review by the Center for Support of Families in December 2016, an internal initiative was undertaken to further strengthen the coordination of the DHHS human

service systems to create a more holistic, multi-generational and integrated approach for individuals, families, and children. As a result of this review, a Child Welfare Systems Transformation Inter-Agency team was established to support these reforms. This team involves a broad group of stakeholders, including parents, staff, medical professionals, law enforcement, educators, legislators, advocates, and providers. The effort has led to several important reforms within and across DHHS's divisions that impact prevention efforts. For DCYF, key reforms have included significant increases in staff capacity as well as increased awareness of efficient ways to organize staff.

As part of this transformation effort, cross-departmental integration teams were also established to understand the barriers to providing effective services for individual and family needs across sectors. Enhanced coordination with DHHS programs in behavioral health, TANF, food stamps and housing were forged to strengthen prevention efforts by effectively coordinating services and supports to at-risk families. Outside of the Department, strengthened partnerships with other state agencies, employers, transportation vendors, childcare providers, and housing services have been important to providing smoother pathways to economic mobility. Figure 1 below visually depicts how these reform efforts further integrated the various health and human service arms of the Department.

Figure 1: DHHS Organizational Chart After Realignment



DHHS Organizational Integration Human Services and Behavioral Health **From left to right – Emphasis on rapid and holistic engagement with integrated, targeted supports and services to prevent deeper involvement and interventions whenever possible and appropriate.*

Bureau of Children's Behavioral Health's (BCBH) enhanced System of Care

In 2018, DHHS released the Adequacy and Enhancement Assessment report (Public Consulting Group, 2018) which called for several reforms that included further integration of services with the children's behavioral health system; immediate enhancements to the service array for children with significant emotional, behavioral and mental health needs; and transformation of New Hampshire's child-serving system to one that is based on early intervention, evidence-based services, and accountability for outcomes. In response, the state legislature passed SB-14 in 2019 to enhance its behavioral health system of care by expanding early and effective community-based interventions and crisis stabilization services. This effort will shift the front door for public behavioral healthcare from the child protection and juvenile justice systems to a System of Care focused upon and available to children based upon their clinical needs regardless of whether they present within the formal child protection and juvenile justice systems.

Expanded services through SB-14 include statewide children's mobile crisis services; utilization of high-fidelity wraparound to support youth with significant behavioral health challenges, including those in need of a residential level of care to better support reintegration into the community; significant enhancements to residential clinical services; development of a conflict free clinical assessment to inform whether and at what level residential care is clinically indicated; and more. These efforts are currently in varying stages of procurement and implementation.

In several respects, this legislation also lays the groundwork for New Hampshire's implementation of Family First prevention services, including the mandate for a uniform clinical assessment of a child and families' needs (i.e., the Child and Adolescent Needs and Strengths assessment), the expectation that services be based in evidence by including new definitions of evidence-based services, an understanding that meeting the needs of children and families will require care to be coordinated across systems, and that families need to understand the options and opportunities for the care of their child(ren).

The forthcoming implementation of Family First looks to further strengthen the collaboration between DCYF and BCBH to meet the needs of New Hampshire families with behavioral health needs. This will be most evident in the rollout of the CBVS program to ensure families with identified mental health and substance abuse needs receive coordinated care.

Family Resource Centers and Establishment of Kinship Navigator Programs

Supported by the New Hampshire Children's Trust (NHCT), Family Resources Centers offer in-home support, parenting programs, various groups and programs for children and youth such as developmental screening and after school programs. They partner with many other

community and government agencies and have comprehensive networks with their own local areas. In support of the Division's vision for Family First, FRCs began to offer kinship navigator services across its 20 sites in late 2020 to provide assistance to family members who have taken on the role of caretakers for children to prevent their entry into the child welfare system.

The Kinship Navigator Program creates a single point of entry to connect relative caregivers with a range of supportive services. These services include coordination and case management, caregiver education, clinical services, peer support and mentoring, legal advocacy, financial assistance (e.g., TANF, SSI, SNAP, child support, housing), and access to other concrete supports. The program also promotes partnerships among DHHS, private, and community-based agencies to broaden access to kinship-related services. To ensure consistent practice, Kinship Navigators have access to a common service delivery platform known as the Family Support Data System which is used to capture data and outcomes across programs.

In 2019, NHCT was awarded a two-year contract to assume the role of a facilitating organization to provide backbone support, coordination, training, and technical assistance for the implementation of operational and quality control standards for the state's network of FRCs. NHCT provides guidance, support and training to FRCs and other community programs providing wellness and primary prevention services for children and families by promoting quality, evidence-based programming, developing mechanisms for cross-network collaboration and progress monitoring, data collection and analysis, and guidance to programs implementing the National Standards of Quality for Family Strengthening and Support (Standards) and/or seeking Family Resource Center of Quality (FRC-Q) designation.

Establishing a Family Support Warm Line

In early 2020, DHHS, in partnership with a community-based provider Waypoint, supported the establishment of a Family Support Warm Line in response to the threat of COVID-19 in New Hampshire. The Warm Line is a free phone-in service where callers can talk confidentially to a family support professional to get help with everything from coping strategies, child behaviors, family dynamics, household management and emotional distress, to gaining access to tools, resources, and services that can help navigate life during challenging times. The ultimate goal of the Family Support Warm Line is to serve as a support to families during times of increased stress and to reduce the number of calls to protective services.

Creation and Distribution of New Hampshire's Child and Family Well-Being Guide

At the onset of COVID, DCYF engaged community members, providers, and parents to develop the Child and Family Well-Being Guide. The brief guide leads community helpers – educators, law enforcement, medical personnel, neighbors, anyone – through a supportive process to engage with children and families and help connect them to resources. Focusing upon the

reality that all families need support, the guide aims to destigmatize and encourage families and community members to seek and accept assistance. The guide was featured in press coverage; distributed to tens of thousands of people through providers, the NH Department of Education, the NH Department of Justice, the NH National Guard, and others; and has been used to support a transformation of practice at the state's child abuse and neglect hotline.

Shifting Child Abuse Hotline Practice to Connect Reporters with Supportive Family Resources

An early focus of the transformation that DCYF began in 2016 has been to find ways to ensure that the right intervention is made available when concerns about a family are made to the child abuse and neglect hotline. New Hampshire's hotline historically provided a binary response to concerns of abuse or neglect: calls were either screened-in or screened-out. Recognizing that a child protection investigation is not always the best intervention and may in fact result in families turning away from supports, work was initiated to identify the types of concerns that tend to result in low risk/unfounded assessments. Over the past year, the hotline has screened-out more of those types of concerns and has more frequently connected reporters with community resources – home visiting programs, families resource centers (FRCs), or sometimes simply providing the Child and Family Well-Being guide.

In a similar effort, in late 2020, DCYF initiated work with Casey Family Programs and Evident Change, formerly known of the National Council on Crime and Delinquency, to create a web-based community response guide. The project is being led by a team including representatives of DCYF, parents, the Child Advocate, Waypoint, CASA, the Granite State Children's Alliance, the Children's Hospital at Dartmouth Hitchcock, the Division of Public Health Services, and the Division of Economic and Housing Stability. The goal is to create a web-based tool to help people concerned about the safety or well-being of a child determine if a report to the child abuse hotline is indicated, or, rather, if a community resource is the best way to support the family. If the latter is indicated, the user will be provided with information for the appropriate local resources to support the family.

Whole Family Approach to Jobs: Parents Working and Children Thriving

Whole Family Approach to Jobs is an ACF Region One and philanthropic initiative to help New England states find innovative solutions that help parents work and children thrive. In 2020, the vast majority of allegations to the hotline are related to neglect. It is believed that a root cause of these concerns is often related to poverty.

Launched in 2017, the six New England states agreed to create a learning community across interest areas, programs, agencies, geography, and political landscapes. The New Hampshire chapter has prioritized solving the vexing issues of poverty by eliminating the cliff effect. The

cliff effect occurs when wages do not make up for what is lost in public assistance when a parent accepts a job or a promotion.

DHHS is working collaboratively across state government, non-profit organizations, philanthropy, and business to promote the upward economic mobility of families and to strengthen the economy by expanding the labor pool for parents. There are five (5) main components to New Hampshire's participation in the Whole Family Approach to Jobs initiative 1) NH Chapter of the Whole Family Approach to Jobs: Parents Working, Children Thriving; 2) House Bill 4 Benefits Cliff Working Group; 3) DHHS Whole Families Integration Team; 4) Economic Analysis of the Cliff Effect; and 5) the development of a benefits cliff calculator.

Community Collaborations to Strengthen and Preserve Families (CCSPF)

New Hampshire's Department of Health and Human Services (DHHS) is the only state agency in the nation to receive federal funding focused on testing new models for family strengthening and prevention supports by creating locally designed, seamless delivery systems. The Community Collaborations to Strengthen and Preserve Families (CCSPF) grant is a five-year award that will allow state and local partners to focus on using evidence-based practices to build parental capacities and self-sufficiency in young families to safely care for their children.

New Hampshire's approach is to lean on the Division of Public Health Services' (DPHS) experience of prevention programming and data driven systems development to support innovative, silo-busting work within rural and urban communities to: (1) reduce the number of children entering foster care, reduce unnecessary referrals to child welfare and increase parental protective factors; (2) strengthen collaboration and coordination across community and state agencies; and (3) use population health and safety needs data to show where future child maltreatment maybe more likely and better target community resources and strategies. At the state and community level, the CCSPF initiative represents a full commitment to multidisciplinary shared planning and decision-making.

The initiative uses the research of Predict Align Prevent, the Protective Factors Framework, and Boundary Spanning Leadership to strengthen its approach (Predict, Align, Prevent. 2021; Center for Creative Leadership, 2016). CCSPF establishes an integrated continuum of family support with community-based services such as mental health, substance misuse treatment, economic supports, home visiting, and educational programs in order to prevent child abuse and neglect, adverse childhood experiences and ultimately reduce the number of children entering foster care. The initiative is focused in three New Hampshire communities of highest need: Manchester, Winnipesaukee Public Health Region (WPHR), and the North Country.

Thriving Families Safer Children initiative

In late 2020, a multidisciplinary team of leaders across the social service sector came together, with the support of Governor Sununu to join the Thriving Families Safer Children initiative with a goal of establishing a cohesive and robust child and family well-being system, capable of meeting the needs of children and families in the community and outside of the formal child protection system. To do so, the state will build on its recent efforts to fortify the Division for Children, Youth and Families, its behavioral healthcare system, and other health and human services and supports.

With input across stakeholders including parents, grandparents, legislators, professionals, businesses, local/regional coalitions, state agency staff and higher education, will harness the momentum of the aforementioned initiatives to create an effective, efficient, and evidenced-informed child and family well-being system.

In consideration of the efforts highlighted in the Thriving Families, Safer Children Round Two proposal, New Hampshire is particularly interested in support and expertise to achieve or advance efforts in the following areas:

- Supporting, sustaining, and expanding robust networks of community based primary prevention supports such as New Hampshire's network of Family Resource Centers;
- Supporting, sustaining, and expanding the newly developed Warm Line and community responses as an alternative to child abuse hotlines for situations in which child maltreatment is not suspected;
- Cross-system, cross-sector data sharing and data linkages;
- Leveraging other jurisdictional initiatives such as the Community Collaborations Grant and Preschool Development Grant;
- Supporting, sustaining, and expanding statewide home visiting programs;
- Expanding upon existing efforts to integrate family/youth/community expertise into design, operation and improvement of well-being systems;
- Supporting the Council to identify and develop strategies to address systemic barriers to creating a well-being system; and
- Advocating for more flexibility in the use of federal funding streams to support well-being across the human services continuum, particularly related to siloed services and distinct eligibility requirements.

Stakeholder Consultation and Coordination in the Planning Process

To plan for the implementation of Family First, DCYF along with its sister agencies have established several supporting work groups, including Case Planning, Technology, Service Array, Assessment, Fiscal, and Communications. A core team from these workgroups meets on a bi-

weekly basis to provide further oversight to the planning process. Executive leadership from DCYF and BCBH have also continually met with representatives of these workgroups throughout the planning process, including as part of a monthly meeting where leaders from the individual workgroups report out directly to DCYF and BCBH leadership. This monthly meeting is designed to problem solve specific planning and implementation concerns. Please see Appendix A for more detail about DCYF's Family First governance structure.

Coordination of IV-B plan and IV-E prevention services

New Hampshire will ensure that their Family First Title IV-E and Title IV-B goals align. The New Hampshire prevention plan will function alongside other prevention programs and funds, such as Promoting Safe and Stable Families (PSSF) funding, which funds family violence prevention services and the Roadmap to Reunification program. DCYF also leverages its Title IV-B funding to support the lower risk prevention population through Family Resource Centers (FRCs), the higher risk SUD populations by supporting the Master Licensed Alcohol and Drug Counselor (MLADC) program and expedited reunification for children in foster and relative placements through Roadmap to Reunification.

DCYF's Bureau of Community, Family, and Program Support is responsible for the program and contract management for both the services outlined in the Title IV-E prevention plan and the services provided under the state Title IV-B plan. For example, the MLADC program is administered by the same unit who will oversee the well-supported evidence-based services illustrated within this prevention plan. This allows for a streamlined, coordinated approach to managing and assessing the effectiveness of these programs, and allows DCYF to ensure that families are receiving the most appropriate service, regardless of funding source.

DCYF is committed to programs and processes that complement each other and serve the overall purpose of creating a robust service array that creates and supports a full system of care for children, youth, and families.

Section 2: Candidacy Groups *(pre-print section 9)*

In mid-2020, DCYF conducted a series of analyses to inform its selection of the target populations for the Family First prevention services. These analyses were focused on understanding the size, distribution, and needs of the populations of children and families who might benefit from evidence-based interventions. While empirical analyses examined a number of different groups, the Family First planning team ultimately selected six target categories of families in this initial five-year Prevention Plan (please see Table 1 below).

Table 1: New Hampshire Candidacy Groups based on SFY2019 or SFY2020 data

Subpopulation Description	Count[1]
1. Children of families at investigation with no court involvement	
a. SDM safe score; high or very-high risk score	2,024 families
b. SDM safe score; moderate risk score	3,370 families
2. Children of families served in-home with an open DCYF case, either voluntary or court involved	1,171 children
3. Children born to mothers with a positive toxicology screening	403 children[2]
4. Children served with an open in-home juvenile justice case, either voluntary or court-involved	2,125 children
5. Children in recently reunified families	611 children
6. Children in recently adopted families	208 children
7. Children remaining in the home with at least one sibling in placement	319 children
8. Pregnant and Parenting Youth in Foster Care	5 – 10 children

[1] An analysis of the subpopulations could not provide uniform years and units (children v. families). Please also note that some candidacy groups with respect to one another are not unique counts.

[2] The counts for the Children born to mothers with a positive toxicology screening candidate group are not unique to the other identified candidate groups (e.g., Children with Safe and Very High referrals scores as the point of assessment).

Children of families during investigation who are deemed safe but moderate to high risk and no current court involvement

One of DCYF's primary goals through the implementation of Family First is to prevent families who come to the attention of the Division from requiring a future Child Protective Services (CPS) intervention. A recent analysis found that 32% of all families investigated by CPS in CY 2017 were subsequently reinvestigated within 12 months, while 40% returned within 18 months. This cycle of recurrence suggests that some families' underlying needs and challenges linked to maltreatment are not being sufficiently addressed through existing supports (New Hampshire Department of Health and Human Services, 2020b).

To understand more about the need to expand community-based service options for families who receive investigations but are not opened as an in-home or CPS case, DCYF performed an analysis of families in SFY2019 with a safe score on the Structured Decision Making (SDM) Safety Assessment, moderate to very-high scores on the SDM Risk Assessment, and an unfounded investigation finding. Among those deemed safe, but high to very high risk, 41% presented with a caregiver history of substance use, 20% with caregiver mental health concerns or physical disability identified, 24% acknowledged incidents of domestic violence, 24% with a child with mental health concerns or a disability, and approximately half (49%) were involved in a

subsequent investigation in the follow-up period. Although exhibiting lower overall levels of risks in comparison to the high to very high-risk subgroup, the moderate risk subgroup also demonstrated similar levels of risk in some areas. For instance, the moderate risk subgroup had similar rates of a child with mental health concerns or a disability than the high to very high-risk group (19 vs 24 %, respectively). Overall, the results of this analysis demonstrate the importance of addressing certain risks to safeguard against subsequent involvement. Please see Table 2 further below.

The families who are referred to Community Based Voluntary Services (CBVS) are transitioned over to the service as their investigation with DCYF is closed out and concluded. Therefore, the families who are involved with CBVS are no longer provided support or services from DCYF itself but rather an outside entity, the CBVS vendor. The clients who are referred to the CBVS vendor are those rating within the high/very high-risk level and deemed safe. All families who are within this criteria are offered the CBVS program, which a referral is then made if the family is interested in the service. The CBVS referrals occur when the family's investigation is completed and determined that legal action is not being taken by DCYF. Families who are involved with CBVS will be documented as eligible for prevention services and will fit within the criteria for the candidacy prevention types for the Family First Prevention Services Act.

Table 2: SFY2019 Population of Safe, Moderate to Very High, and Unfounded at Investigation

	Safe, High/Very High Risk, Unfounded	**Safe, Moderate Risk, Unfounded,**
Demographic features	• Average age of a primary caregiver is 34 years old • Average number of children in a family is 2 children • 48% with children 5 yrs. old and younger	• Average age of a primary caregiver is 34 years old • Average number of children in a family is 2 children • 40% with children 5 yrs. old and younger
Prior interactions	• 12% had no prior interaction • 25% had a call but were screened out • 63% had a call and had an assessment	• 51% had no prior interaction • 18% had a call but were screened out • 31% had a call and had an assessment
Subsequent interactions	• 24% had no subsequent interaction • 27% had a call but were screened out • 49% had a call and had an assessment	• 51% had no subsequent interaction • 19% had a call but were screened out • 30% had a call and had an assessment
Substance Use Disorders	• 41% have SU identified in their most recent assessment • Among those, 52% have both SU and a young child	• 21% have SU identified in their most recent assessment • Among those, 47% had both SU and a young child

Mental Health or Physical Disabilities	• 20% have a MH or Physical Disability among the caregiver identified in their most recent assessment • 24% have a MH or Physical Disability among the child identified in their most recent assessment	• 9% have a MH or Physical Disability among the caregiver identified in their most recent assessment • 19% have a MH or Physical Disability among the child identified in their most recent assessment
Domestic Violence	• 24% have DV identified in their most recent assessment	• 17% have DV identified in their most recent assessment

Given these overall findings, New Hampshire has opted to include families who are deemed safe with moderate to very high-risk scores at investigation as a candidate subgroup for Family First.

As discussed in the previous section, those families who score as safe on the Structured Decision Making (SDM) Safety assessment and high or very high on the SDM Risk Assessment tool will be eligible for referral to the Community-Based Voluntary Services (CBVS) program. Launched in early-2021, DCYF estimates that approximately 2,000 families per year will be eligible for referral.

Although the majority of these CBVS referrals will have unfounded or inconclusive investigative findings, DCYF also plans to refer families with "founded – problem resolved" population if deemed appropriate. Additionally, there will be consideration to referring families with a moderate score on the SDM Risk Assessment to the CBVS program in the future.

Given that a considerable proportion of this population are families with children 5 years old and younger (48 % for high to very high risk and 40% for moderate risk), DCYF plans to ensure better coordination with its sister agency, the Division of Public Health Services (DPHS), and community providers to expand access and linkage to home visiting services. This will be achieved through referral to the CBVS program for further assessment and care coordination or by direct referral to a home visiting program such as Healthy Families America.

Children of families in open In-Home (Court or Voluntary) Services

In SFY19 DCYF served 1,307 children or 675 families through in-home voluntary or court involved cases. During a DCYF investigation, families that are typically included in this subpopulation are those with an SDM Safety Assessment rating of conditionally safe but unable to address safety concerns; or a SDM Risk Assessment Tool rating of high or very risk and a DCYF allegation finding determination of founded.

As a proxy for understanding the needs of this population, DCYF analyzed SFY19 data for those families with a conditionally safe SDM safety score at investigation but families with any risk level or investigation finding status. Among this population of 1,444 families, 52.9% had past or

present substance use, 28.8% were involved with domestic violence, 21.8% had a caregiver with a mental health or physical disability, and 56% had at least one child under the age of 5.

To supplement these safety assessment findings, the Division facilitated focus groups and interviews with direct service staff and local providers to obtain qualitative insights on the needs of families being served not just as an open in-home case but for those who had been recently reunified or were residing with a relative caregiver. These qualitative findings reinforced that parental substance use and mental health, domestic violence were primary reasons for CPS involvement. In addition, the discussions emphasized the need to further bolster concrete supports, particularly housing and transportation, to further safeguard against out-of-home care (New Hampshire Division of Children, Youth & Families, 2020).

Children born to mothers with a positive toxicology screening

In SFY2020, DCYF assessed families with 403 substance exposed infants (SEI). Of those families with SEI who have recorded SDM tool results during the investigation, 64% scored high or very high risk and 46% were assessed as unsafe or conditionally safe. Among this population, 13% were involved with domestic violence, 20% had a caregiver with a mental health or physical disability, and 7% had a child with a mental health or physical disability. Relatedly, in CY2020, approximately 1 in 5 DCYF critical incidents (primarily fatalities, near-fatalities, and other serious issues) involved a substance exposed infant. History of prenatal substance exposure continues to be a leading concern for out of home placement across the state, with 430 children removed by DCYF from 2015-2019 (New Hampshire Office of the Child Advocate, 2019). Family First prevention services will be considered for any family with a SEI to expand DCYF's service array options with these families.

Children served by Juvenile Justice Services (JJS) In-Home

DCYF's Juvenile Justice Services (JJS) program is responsible for providing supervision and rehabilitative services to youth at risk or involved with the juvenile justice system. The program provides supervision, case management, and an array of rehabilitative services through Juvenile Probation and Parole Officers (JPPOs) and a network of community-based providers who are licensed or certified by DHHS.

In 2020, NH DCYF served 2,125 youth in-home with JJS cases. This population is made up of cases that are deemed Children in Need of Services (CHINS), voluntary CHINS, and non-CHINS delinquency cases. CHINS cases are those with a court petition filed to assist children experiencing serious difficulties and who need services in order to protect the child from the long-lasting impact of harmful behavior. These petitions may be filed by parents, guardians, schools or law enforcement depending upon the behavior which is alleged. For some families, a CHINS case is opened on a voluntary basis without a court ruling.

The Structured Assessment of Violence Risk in Youth (SAVRY) has historically been administered to youth involved with JJS. The SAVRY measures whether the youth is at relatively low, moderate or high risk for engaging in violence or general delinquency. The instrument's specific items also provide relevant indications on family/caregiver support, child mental health, and child substance abuse. However, SAVRY quantitative results for the JJS population are not available currently. In response, DCYF engaged in a series of focus groups with its JJS staff in late 2020 to understand the specific needs of this population. According to staff, among the challenges that the majority of the JJS population face are unresolved traumas, clinical mental health and substance abuse concerns, lack of educational engagement, exposure to negative peer groups, and lack of parental skills and supports (NH DCYF Focus Group, 2020). Given the substantial risk for JJS youth to become dually involved with Child Protective Services, DCYF is committed to providing additional services through Family First to support positive youth and family outcomes.

Children who are recently reunified

In SFY2020, DCYF served a total of 611 children (376 from CPS and 235 from JJS) exiting care to reunification. Prior research from the field indicates that some of these children are at-risk of returning to care without needed supports and resources (Wulczyn et al., 2020). In fact, in the previous year (SFY 2019), 14.8% of 531 children entering foster care were re-entries; of those children 8.1% re-entered within 12 months and 6.8% re-entered more than 13 months after reunification. This finding suggests that some children and their families could benefit from additional Family First prevention services to reduce the likelihood of re-entry.

As discussed further above, the Division facilitated focus groups and interviews with direct service staff and local providers to obtain qualitative insights on the needs of families recently reunified, families being served through in-home services, or children residing with a relative caregiver. Staff emphasized that parental substance use and mental health, domestic violence were primary reasons for CPS involvement (New Hampshire Division for Children, Youth & Families, 2020). Such findings suggest a need to support recently unified children and families to prevent further re-entry into the system. Family First prevention services will be considered for any child who has recently been reunified for whom services to the family will mitigate identified risks, preventing further maltreatment and re-entry into care.

Children who are recently adopted

In SFY2019, DCYF served 26 post-adoption children and families. Although adoption failure rates are not available at this time, a survey of foster and adoptive parents that was conducted in 2015 and 2018 (n=622) provided some important insights on adopted children in New Hampshire. Although 39% of the respondents in this survey also included foster parents in

addition to adoptive parents, it provides a proxy of the needs of adoptive children across the state. According to respondents, families requested a need for more appropriate mental health resources for kids with trauma and attachment concerns, parental support services like childcare and summer programming, and educational support such as IEP coordination with schools (Center for Program Design and Evaluation at Dartmouth, 2018).

Children remaining in the home whose siblings are in placement

Given that siblings in the same family may potentially be removed on different dates, an analysis was performed using data from every first of the month of SFY2020. On average, across these months, there were 1,060 children in placement. Among these children in placement, there were 319 siblings remaining at home. Research findings have indicated that if there is a safety factor that caused the removal of one child, the remaining children in the home may be at greater risk of coming into care (Witte, Fergert & Walper, 2018). These findings suggests that some children and their families could benefit from additional Family First prevention services to reduce the likelihood of re-entry.

Pregnant and parenting youth in foster care

FFPSA allows for prevention services for pregnant or parenting foster youth. In SFY 2020, based on current tracking methods, DCYF estimates that there are between 5 – 10 youth in this sub-population each year. DCYF anticipates that more refined tracking methods will identify an additional need in this area. Prevention services to or on behalf of the youth will help ensure that the youth is prepared to be a parent so that their unique needs are met and their efforts to transition to adulthood are successful.

Section 3: Title IV-E Prevention Services *(pre-print section 1; Attachment III)*

To ensure a rigorous selection process for the proposed Family First prevention services, several important factors were considered by stakeholders, including 1) the size and needs of the target populations (Section 2); 2) evidence ratings from the Title IV-E Prevention Services Clearinghouse and findings from peer-reviewed literature; 3) the existing array and capacity of interventions already provided by DHHS sister agencies or through other funding streams; and 4) the cost and feasibility of implementing various evidence-based programs relative to population needs and anticipated cost-benefit expectation associated with program implementation. Based on this selection process, the information detailed in Table 3 represents the array of preventive programs that aligns with the needs of children and families involved with or at risk for becoming involved with New Hampshire's child welfare system.

Table 3: New Hampshire Family First Service Array

Service Type	Intervention	Target Population	Length of Service (LOS)	IV-E Clearinghouse Rating	Funding Source(s)
Parenting Skills	Healthy Families America (HFA)	Families with children aged 0 – 5	36 - 60 months	Well Supported	Family First, MIECHV
	Homebuilders	Families and children/youth	4-6 weeks	Well Supported	Family First, Medicaid
	Intercept	Families and children/youth	Mostly 4-6 months, can be 6-9 months for post-reunification cases	Well Supported	Family First, Medicaid
Mental Health & Substance Abuse	Multisystemic Therapy (MST)	Youth aged 12-17 with serious emotional/behavioral difficulties needs & their families	4 – 6 months	Well Supported	Family First, Medicaid
Parenting Skills, Mental Health, Substance Abuse	Motivational Interviewing (MI)	Families and youth	As needed throughout a case	Well Supported[1]	Family First

[1] Currently, the IV-E Prevention Services Clearinghouse has only rated MI as a favorable practice for substance abuse. New Hampshire DCYF is currently investing in Motivational Interviewing (MI) as a casework practice and client engagement strategy for all involved families in the Community-based Voluntary Services (CBVS) program

Rationale for Family First Intervention Selection

Healthy Families America

Healthy Families America (HFA) is an intensive, long-term home-visiting program tailored to families who experience complex risk factors in their past or present such as a history of trauma, intimate partner violence, mental health concerns, and/or substance misuse or substance use disorders. NH plans to implement Healthy Families America. (2018) *Best practice standards*. Prevent Child Abuse America.

The Division of Public Health Services (DPHS) offers 250 slots of the flagship HFA model through local implementing agencies (LIAs) across the state with support from the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, an initiative funded by the Health Resources and Services Administration (HRSA), in partnership with the Administration for Children and

Families (ACF). Typically, families are eligible to receive services under the flagship HFA model beginning prenatally or within three months of birth, with an allowance for up to 20% of a site's caseload to enroll outside of the prenatal to 3-month window but prior to 24 months of age for the target child.

Families enrolling in HFA are required to be offered services for a minimum of three years, however, it should be noted that families have the autonomy to choose to exit the program prior to completion of three years of services if they so choose. The frequency of home visits for newly enrolled families begins weekly for families enrolled in the third trimester of pregnancy or postnatally and remains weekly through at least the first six months of services, gradually decreasing over time, depending on the family's attainment of new skills, achievement of goals, and needs of the caregiver and family.

Starting in 2022, DCYF is planning to use IV-E funding to expand capacity of these services to support the proposed candidate subgroups using the HFA child welfare protocols, a variation within the traditional HFA model that is designed to serve the families of children who have increased risk for maltreatment or other adverse childhood experiences. DCYF will look to claim IV-E funding for up to 200 families served annually through the HFA child welfare protocols. Services delivered under the HFA child welfare protocols are the same as the services delivered under the standard HFA model. The only requirement that is different in practice with the child welfare protocol is that it allows all families referred by the child welfare system to be enrolled up until the target child is 24 months old (Healthy Families America, 2018). The child welfare protocols also require additional training for providers to serve families with children aged 3 to 5 years old.

HFA will be targeted to pregnant and parenting youth in care, aged 13-21, and pregnant women and new parents of children who are up to 24 months of age at enrollment. The planned age range specific to enrollment of the HFA Child Welfare Protocol is for parents of children up to 24-months of age. The planned age range for the provision of the program is for parents of children up to 5 years of age to allow for the full-service length of 36 months per HFA protocol.

As noted above, New Hampshire DCYF expects to serve up to 200 families per year through HFA with planned incremental increases based on uptake and need. DCYF and DPHS will continue to ensure that contracted providers utilize the manual referenced on the IV-E Prevention Services Clearinghouse and available on the HFA website (Healthy Families America, 2017) as well as the child welfare protocols (Healthy Families America, 2018).

DCYF anticipates that Healthy Families America will achieve positive outcomes in several short-term and long-term measures with the target population described above. Specifically, DCYF hopes to reduce maltreatment for families participating in the program; a decreased proportion of families with no new accepted DCYF referrals/assessments while enrolled in HFA, and no new founded maltreatment findings while enrolled in HFA. By working with the NH Division of Public

Health Services (DPHS), DCYF is looking to expand the current statewide provision of the traditional HFA model to also include the child welfare protocols so that DCYF can serve families involved with child welfare up to age 5. Much like the CBVS program, families will often be served at the conclusion of their DCYF case, and their participation will be voluntary. Therefore, family engagement and enrollment will be paramount to the success of the program and one of the key metrics that will be tracked. Additional outcomes that will be part of the joint monitoring process between DPHS and DCYF are listed in Section 6 of this plan under "DCYF CQI Strategy for Well-Supported Interventions."

Homebuilders

Homebuilders is a home- and community-based intensive family preservation services treatment program designed to avoid unnecessary placement of children and youth (0-18 years old) into foster care, group care, psychiatric hospitals, or juvenile justice facilities. The program model engages families by delivering services in their natural environment, at times when they are most receptive to learning, and by enlisting them as partners in assessment, goal setting, and treatment planning. Homebuilders services are concentrated during a period of 4 to 6 weeks. Families typically received 40 or more hours of direct face-to-face service. Homebuilders' therapists typically have small caseloads of 2 families at a time and are available to family members 24 hours per day, 7 days per week. The model's practitioners conduct behaviorally specific, ongoing and holistic assessment and collaborate with the family in developing intervention goals and service plans. The intervention focuses specifically on factors related to the risk of out-of-home care. Throughout the intervention, the practitioner develops safety plans and uses clinical strategies designed to promote safety. Homebuilders is well-supported on the IV-E Prevention Services Clearinghouse.

New Hampshire plans to employ Homebuilders with children ages infant – 18 years who are referred to CBVS or who have open in-home DCYF cases (voluntary or involuntary). DCYF expects approximately 150 families per year to be eligible for Homebuilders, with the current procurement plan to serve up to 100 per year in this initial implementation. Title IV-E reimbursement will only be claimed when the family's Medicaid or private insurance does not cover this service. Contracted providers will utilize the Homebuilders manual, Keeping Families Together: The Homebuilder Model, and will not use any adaptations to the Homebuilders Model (Kinney, Haapala & Booth, 1991).

DCYF anticipates that Homebuilders will achieve positive outcomes in several short-term and long-term measures with the target population described above. DCYF recognizes the unique intensity of the Homebuilders service and is positioning it as such within our continuum of evidence-based programming. This will allow staff to access Homebuilders for families who require the most intensive, short-term service. Specifically, by providing a service that intervenes within 24 hours of referral and provides an average of 10 hours of support per week

for four weeks, DCYF anticipates that more families will be preserved, strengthened and the likelihood of a child's removal will be greatly reduced as a result of the 4-week Homebuilders service intervention. Key indicators of program fidelity and success will be tracked and monitored throughout the contract. These indicators include number of families seen within 24 hours of referral, number of families who complete the 40 hours of treatment sessions during the 4 weeks of the program along with successful outcome indicators such as a reduction in repeat maltreatment and children successfully remaining in their home at key intervals (6 and 12 months) following the completion of treatment. Additional outcomes of the Homebuilders program that DCYF will track are listed in Section 6 of this plan under "DCYF CQI Strategy for Well-Supported Interventions."

Multisystemic Therapy

Multisystemic therapy (MST) is an intervention offering treatment for youth aged 12 – 17 who are involved or at risk for involvement with the juvenile justice system and have significant substance abuse issues or mental health concerns. The model is a community-based intensive service provided at least once per week (up to daily) with clinical services available to youth and their family 24 hours a day for an average of three to five months. The program aims to promote prosocial behavior and reduce criminal activity by addressing the core causes of delinquent and antisocial conduct. The key drivers of the youth's antisocial behavior are identified through an ecological assessment of the home, school and community settings.

An analysis of calendar year 2019, suggest that approximately 300 JJ-involved adolescents comprise the target population each year. DCYF estimates that the MST target population skews toward the older end of the JJS population and includes a disproportionately large share of youth of color (between 20-40%), and 75% identifying as male. Implemented as a new intervention in 2021, DCYF is currently procuring services to provide MST to approximately 250 youth per year across the state. Most of these referrals will likely include youth with current or prior JJS involvement. DCYF will seek to claim MST under Title IV-E when the family's Medicaid or private insurance does not cover this service.

DCYF will not use any adaptations to the standard MST model and will contractually require that providers utilize the manual reviewed by the IV-E Prevention Services Clearinghouse (Henggeler, Schoenwalk, Borduin, Rowland & Cunningham, 2009).

DCYF anticipates that MST will achieve positive outcomes in several short-term and long-term measures with the target population described above. By positioning MST as the foundational prevention service for youth involved with juvenile justice, DCYF predicts that fewer youth involved with the JJ system will require out-of-home placement, specifically placement in a

residential setting. Additionally, this service provides intense support to the youth's caregiver, which allows for long term, sustained success and prevents not only placement, but future involvement with juvenile justice. Through MST's model and work with the youth, DCYF also anticipates that youth who receive MST will commit fewer offenses and experience shorter time on probation. These outcomes will be tracked and monitored through ongoing data sharing and discussion between DCYF, and the MST contracted vendor. Additional MST outcomes that DCYF will track are listed in Section 6 of this plan under "DCYF CQI Strategy for Well-Supported Interventions."

Motivational Interviewing (MI)

Motivational Interviewing (MI) is a client-centered counseling method that aims to develop the client's internal motivation to achieve behavioral change. The model assists with identifying ambivalence for change and increase motivation by helping clients progress through five stages of change: pre-contemplation, contemplation, preparation, action, and maintenance. It aims to do this by encouraging clients to consider their personal goals and how their current behaviors may compete with attainment of these goals. MI uses clinical strategies to help clients identify reasons to change their behavior and reinforce that behavior change is possible.

Research has demonstrated MI's effectiveness in bringing about a wide range of behavior changes when used as a standalone intervention, including multiple studies suggesting its effectiveness in a child welfare setting. Additional findings bolster MI's effectiveness when paired with other interventions (Forrester, McCambridge, Waissbein, Emlyn-Jones, & Rollnick 2008; Shah, Jeffries, Cheatham, Hasenbein, Creel, Nelson-Gardell, & White-Chapman, 2019; Miller & Rollnick; 2012). Please refer to section 6 for a review of MI's effectiveness.

The Community Based Voluntary Services (CBVS) model relies heavily on the ability of provider staff to encourage and motivate meaningful connections and engagement both in CBVS and additional supports and services. As a result, DCYF has worked with its two private CBVS providers to integrate Motivational Interviewing (MI) into its service model. Through increased engagement, we anticipate better service matching to the needs of each child and family. MI's client-centered approach will support sustainment of the family's motivation toward progress, so each child and family are able to continue to receive an appropriate dose and level of support and service.

The current MI curriculum offered to CBVS family support specialists and their supervisors are provided by a certified MI trainer utilizing the MI manual referenced on the IV-E Prevention Services Clearinghouse to guide implementation (Miller & Rollnick; 2012). The curriculum teaches specialists how to embed MI practice principles into each encounter with families, including initial engagement with the family, developing goals, fostering internal motivation to

change, and promoting service linkage and continued participation in services and supports. Supervisors and contracted trainers will provide critical support to specialists in maintaining fidelity to the MI practice using a standardized fidelity tool and monitoring of a continuous quality improvement plan. The CBVS program model incorporates both Solution-Based Casework (SBC) and Motivational Interviewing. To support accurate and effective billing, CBVS staff (family engagement coordinators, family support specialists, and supervisors) are working on determining the frequency and time spent on average for each activity that each position is responsible for doing. This is to determine the percentage of the CBVS service model that incorporates Motivational Interviewing, thereby allowing DCYF's rate setting unit to determine which portion of the daily CBVS rate uses the Motivational Interviewing model. This determination will allow New Hampshire to claim Motivation Interviewing as its own Title IV-E Prevention Service.

DCYF is utilizing MI within its voluntary CBVS service model. Given this strategy, the short and long-term outcomes will focus primarily on the outreach, enrollment and long-term engagement of families within the CBVS program. DCYF anticipates the successful implementation of Motivational Interviewing will show that a high percentage of families engage, participate and complete the CBVS service. Adherence to MI model fidelity by CBVS vendors will be measured using instruments such as the Motivational Interviewing Treatment Integrity (MITI) and LYSSN, families experiencing improved outcomes between the initial and follow-up scores on the Protective Factors Survey-version 2 (PFS-2), and seeing a reduction in the proportion of families who have subsequent child welfare involvement both during the provision of CBVS services and at key intervals (6 and 12 months) post-discharge. Additional MI outcomes that DCYF will track are listed in Section 6 of this plan under "DCYF CQI Strategy for Well-Supported Interventions."

Intercept

Intercept (formally known as YV Intercept™) is an integrated approach to in-home parenting skill development that offers a variety of evidence-based practices to meet the individualized needs of a family and young person. The program is appropriate for children ranging in age from birth to 18, with services lasting four to nine months (typically, four to six months for prevention or six to nine months for reunification). The model includes crisis supports, skills training and therapeutic interventions to address treatment goals and home stability. Family Intervention Specialists work intensely with both the child and the caregivers to address issues impacting the stability of the family, meeting an average of three times weekly in the home or community, depending on family need, and providing 24-hour on-call crisis support. Intercept employs the following evidence-based practices, as clinically indicated: Adolescent Community

Reinforcement Approach (ACRA), Community Advocacy Project (CAP), Collaborative Problem Solving (CPS), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and Motivational Interviewing (MI). The length of treatment is determined by the needs of the family and their progress. However, diversion services generally last four to six months, while reunification services generally last six to nine months.

Intercept is currently being procured with full implementation planned for early to mid-2022. Upon full implementation New Hampshire plans to employ Intercept to approximately 375 families per year who are referred to CBVS, have an open in-home DCYF cases (voluntary or involuntary), are recently reunified, or involved with JJS. This target population was determined based on analysis of calendar year 2019, specifically focusing on the number of families served through in-home or voluntary child protection cases, either pre-removal or post-reunification that fit within the eligibility requirements of the Intercept model. DCYF will seek to claim Intercept under Title IV-E when the family's Medicaid or private insurance does not cover this service.

The Youth Villages website includes information regarding training and certification, implementation support and documentation. DCYF will contractually require that Youth Villages, who is the only agency that can provide Intercept, will adhere to all fidelity requirements of the Intercept model that was reviewed by the IV-E Prevention Services Clearinghouse (Goldsmith, 2007).

DCYF anticipates that Intercept will achieve positive outcomes in several short-term and long-term measures with the target population described above. DCYF recognizes the intensity, yet broad application, of the Intercept service and is positioning it as such within its continuum of evidence-based programming. This will allow staff to access Intercept for families who require an intensive, parent-skill based service that can serve families within children ages 0-18 before removal and post-reunification, while providing an extended period of support during the reunification period in order to prevent re-entry into care and prolonged involvement with DCYF. Specifically, by providing an intensive service that intervenes within 3 days of referral and provides an average of 3 therapeutic sessions per week for four to six months, DCYF anticipates that more families will be preserved, strengthened and the likelihood of a child's removal will be greatly reduced as a result of the Intercept service intervention. Key indicators of program fidelity and success will be tracked and monitored throughout the contract. These indicators include number of families seen within 3 days of referral, number of families who complete a therapeutic dosage of the program (at least 60 days) along with successful outcome indicators such as a reduction in repeat maltreatment and children successfully remaining in their home at key intervals (6 and 12 months) following the completion of treatment. Additional outcomes of the Intercept program that DCYF will track are listed in Section 6 of this plan under "DCYF CQI Strategy for Well-Supported Interventions."

Intervention for Future Consideration

The intervention below is being considered for future amendment to New Hampshire's IV-E prevention plan. DCYF is currently assessing the feasibility of launching an evaluation to support its inclusion. Until such time, New Hampshire does not plan to claim Title IV-E reimbursement for this intervention.

Child-Parent Psychotherapy (CPP)

Child-Parent Psychotherapy (CPP) is an intervention model for children aged 0-5 who have experienced traumatic events and/or are experiencing mental health, attachment, and/or behavioral problems. The treatment is based in attachment theory but also integrates psychodynamic, developmental, trauma, social learning, and cognitive behavioral theories. Typically, therapeutic sessions focus on the child and primary caregiver dyad. CPP sessions are typically delivered over 20-32 weeks depending on clinical need. Sessions occur in the home or an outpatient setting and last approximately 60-90 minutes. A central goal is to support and strengthen the caregiver-child relationship as a vehicle for restoring and protecting the child's mental health. Treatment also focuses on contextual factors that may affect the caregiver-child relationship (e.g., cultural norms and socioeconomic and immigration related stressors. Targets of the intervention include caregivers' and children's maladaptive representations of themselves and each other and interactions and behaviors that interfere with the child's mental health. For children exposed to trauma, caregiver and child are guided over the course of treatment to create a joint narrative of the traumatic event and to identify and address traumatic triggers that generate dysregulated behaviors and affect.

If implemented, New Hampshire would employ CPP with children ages 0 – 5 years who are referred to CBVS, have an open in-home DCYF cases (voluntary or involuntary), are recently reunified, or involved with JJS.

Trauma-Informed Service Delivery

Trauma-informed care refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing. The Division for Children, Youth and Families has embraced these concepts of trauma-informed care and is actively working to increase its workforce's knowledge of the impact of trauma on those served as well as bolstering trauma treatment services.

DCYF has had a long-standing commitment to a trauma-informed practice and providing training for its CPSWs, JPPOs, and supervisory staff. DCYF currently contracts with Granite State College to provide a core curriculum that infuses trauma-informed training content into the

foundation of pre-certification and continuing education trainings. Several modules within this core curriculum provide education about the impact of trauma on the child and family and teaches skills to ensure that worker engagement, advocacy, assessment, and service planning are aligned to these needs. In addition to the core curriculum, the CWEP offers access to various other trauma-informed care training resources that can be leveraged to increase competency. As Title IV-E prevention services are brought online, DCYF will work closely with the Granite State CWEP and other training entities to design and implement additional trauma-focused prevention practice model training as necessary.

In terms of ensuring trauma-informed care by service providers, a key requirement for service selection was that the model included specific practices to identify trauma among families and address these needs as part of the intervention's approach to treatment. Providers will be contractually required by DCYF to implement all EBPs with fidelity which will include monitoring of trauma-informed elements in the practice. Please see Attachment III for assurance that all services provided under this Title IV-E Prevention Plan will be administered within a trauma informed organizational structure and treatment framework.

Section 4: Child Specific Prevention Plan

Eligibility Determination and Assessment for IV-E Prevention Services

To ensure that the Division correctly identifies children who are at imminent risk for foster care, plan protocols will be developed for each subgroup to help guide staff through the eligibility, assessment, prevention planning, and referral processes. DCYF plans to leverage the current assessment processes for each of the target populations. Several different types of assessments that are performed by child protective service workers and juvenile probation and parole officers at initial intake or ongoing monitoring will inform the eligibility determination process as well assist with appropriate service selection. These include the Structured Decision Making (SDM) Safety Assessment, the SDM Risk Assessment, and the Structured Assessment of Violence Risk in Youth (SAVRY).

The SDM safety and risk tools are a household-based assessment focused on the characteristics and behaviors of the caregivers and children living in that household. By completing at investigation and at subsequent milestones, child protective service workers (CPSWs) obtain an objective appraisal of the immediate safety and potential future risk to a child, respectively. The Structured Assessment of Violence Risk in Youth (SAVRY) is currently administered by juvenile probation and parole officers (JPPOs) to youth involved with JJS. Implementation workgroups are currently working to map the specific risk criteria within each instrument or form to further

operationalize the assessment process and recommendations for specific interventions in the proposed service array.

It should be noted that the Division is currently planning to implement the Child & Adolescent Needs and Strengths (CANS) assessment in 2022/2023 for CPS and JJS cases. Although plans are not fully formulated at this time, the CANS will be administered to families in-home and foster care candidacy groups discussed previously.

Prevention Planning

Child-specific prevention plans will be developed in collaboration with the child, if age and developmentally appropriate, and the child's caregiver(s). CPSWs, CBVS caseworkers, and JPPOs will engage individual family members in understanding the strengths and needs of each person in the family and will integrate the information from the aforementioned assessment tools. Staff responsible for completing a child's plan will be trained in understanding assessment results to inform an eligibility determination and service selection. The same methodology will be used for redetermination of eligibility should there be a need for services beyond twelve (12) months since the submission of the child's initial prevention plan. To understand which staff will be determining eligibility and have responsibility for prevention plan development, please see Table 4 below.

Table 4: Staff Responsible for Determining Eligibility and Developing the Child-Specific Prevention Plan

Target Subpopulation	Staff Determining Eligibility and/or Providing Assessment	Staff Responsible for Developing or Updating the Prevention Plan
Children of families during **investigation who are deemed safe but moderate to high risk and no current court involvement**	DCYF Assessment CPSW	CBVS Caseworker
Children and family members with an **open in-home case through the court or voluntary**	DCYF Assessment CPSW	DCYF Family Services CPSW
Children remaining in the **home with at least one sibling in placement**	DCYF Assessment CPSW	DCYF Family Services CPSW
Pregnant and parenting youth in foster care	DCYF Family Services CPSW Or DCYF JPPO	DCYF Family Services CPSW Or DCYF JPPO
Families with a **juvenile justice involved youth being served via an in-home case**	DCYF JPPO	DCYF JPPO

Families with children who have been **recently reunified** and may be at risk of re-entry	DCYF Family Services CPSW Or DCYF JPPO	DCYF Family Services CPSW Or DCYF JPPO
Families with children who have been **recently adopted**	DCYF Post Adoption CPSW	DCYF Post Adoption CPSW

The family and/or child in consultation with the applicable worker or officer will identify specific goals, service needs, and realistic achievement completion dates to help ensure the child's safety, mitigate risk of future maltreatment and prevent foster care or strengthen parenting capacity. Caseworkers will offer information about available services to address identified needs that are available, taking into account and resolving any barriers that might exist for the family or child to receive an appropriate service.

The development and monitoring of child-specific prevention plans for the children in the proposed candidacy groups will require a tailored approach and multiple process adjustments from existing practice. CBVS providers will establish and maintain the child-specific prevention plans for the children and families they serve. DCYF is currently working to integrate the prevention planning process into their SACWIS (aka Bridges) and other information systems. CBVS providers will also establish and maintain the child-specific prevention plans for the children and families they serve.

Service Referral, Linkage and Monitoring

Currently, DCYF CPSWs and JPPOs identify which services are needed for each family and which provider is available to provide the service. Workers and officers initiate the referrals directly and coordinate warm hand offs with providers to engage the family in service enrollment. The documentation of the service referral is kept both in the Bridges contact logs and in the case file. In the future, DCYF envisions a centralized referral unit similar to one at the Connecticut Department of Children and Families that matches families to the most appropriate service, based on identified risks, needs and service areas.

To monitor the linkage process, CPSWs, CBVS workers and JPPOs will maintain frequent and regular contact with service providers and the family to support service provision, assess progress made and help identify any adjustments needed to services.

For more information about staff practices and workforce development see section 7.

Section 5: Monitoring Child Safety *(pre-print section 3)*

Providing for child safety is an integral role of the Division's CPS and JJS staff as well as contracted CBVS staff. During the time period families are engaged in Family First prevention services, staff will assess the safety of the child for present or impending danger at all contacts. If imminent danger exists, the worker will take immediate protective action.

Ongoing monitoring will be accomplished through one or both of the following mechanisms: 1) formal risk assessment through completion of the SDM Safety assessment, SDM Risk assessment, SAVRY, Child and Adolescent Needs & Strengths (CANS), or other applicable assessment by an assigned CPSW, juvenile probation and parole officer or clinician on an ongoing basis; or 2) informal risk assessment on an ongoing basis, for example though face-to-face conversations and observations of the family dynamics and/or the home while considering information from other sources, such as school and medical staff, therapists, etc. Each unique program serving these subgroups implements different levels of familial contact based upon the risk and family's level of need. CPSWs and JPPOs are required to make, at a minimum, monthly face-to-face visits with a family, with more frequent visits for certain children depending on need.

For the CBVS population, expectations for the frequency of contact with the family is determined by the Solution Based Casework's (SBC) practice model. Grounded in a framework of safety and family engagement, the SBC model focuses on safety outcomes through ongoing engagement with the family, assessment, and its case planning process to ensure specific family and individual level action plans address parental capacity, and child vulnerability. Based on planning conversations with the CBVS providers, it is a general expectation that CBVS specialists will see families approximately 1-4 times monthly per the SBC model. CBVS providers are utilizing various assessments to identify the safety risks and needs for the families through the case involvement. The CBVS caseworkers will consistently monitor the safety and risk within the cases they are assigned and provide family stabilization throughout the case as needed and appropriate. The CBVS vendors are then reporting out the assessment scores at the start of the case and at other identified points in the case to follow up regarding the safety and crisis level.

In reference to the contracts that are developed for EBPs, DCYF has identified teams that meet with the agencies to provide active contract management and performance improvement tasks. These meetings are intended to assist in discussing and monitoring the performance of the provider(s) and developing any plans to improve services.

For CBVS, the provider agency's staff is responsible for developing and implementing the treatment plan for the clients and families. To measure safety and risk, the CBVS provider is required to complete the Protective Factors II survey and score the skills of the parent(s)/family. The Family Support Worker (FSW) working with the family is the one to complete the survey and

assessment with the family to determine an accurate measurement on skill levels, as well as the role that continues the ongoing work with the family. The CBVS provider is developing the child specific prevention plan for the identified child. The provider is utilizing Solution-Based Casework to move towards the development of consensus in order to establish the prevention plan and objectives for the overall service. CBVS staff connect with the families throughout the week to provide the ongoing case management support and identify any immediate needs for stabilization for each family. There is continued assessment of safety and risk for each of the identified families, which can include, if concerns arise, being brought forth to DCYF's attention for further assessment. The CBVS staff will continually be aware to identify any safety and/or risks for the child or family while working through the six months of the service. Throughout the length of the CBVS case, the provider will be utilizing Solution-Based Casework and Motivational Interviewing.

To further support comprehensive assessing and addressing of safety and risk for each child and family, New Hampshire DCYF has three mechanisms to be used by CBVS staff to bring forth concerns of abuse or neglect. First, NH RSA 169-C:29-31 is the state reporting law for child abuse or neglect. CBVS staff are bound by this law as mandated reporters. Second, the CBVS vendors are contractually required to report to DCYF Central Intake any suspicion of child abuse or neglect. Lastly, the DCYF Service Array team facilitates monthly performance improvement meetings with both CBVS vendors. These planned meetings review performance data, discuss service provision and overall compliance with contractual requirements. These meetings also provide the forum for the vendors to bring any case-specific concerns they have regarding potential child abuse or neglect in the families they are serving.

Please refer to Table 5 below for the list of staff roles, timeframes for contact, and the formal assessment tools and timeframes by subpopulation.

Table 5: Responsibility for Risk and Safety Monitoring and Supporting Protocols

Target Subpopulation	Staff Responsible	Timeframes for Contact with Families	Timeframes for Ongoing Formal Risk Assessment
Children of families during **investigation who are deemed safe but moderate to high risk and no current court involvement**	Assessment CPSW; CBVS Worker	CBVS specialist sees a family 1-4 times monthly per Solutions Based Casework model	Protective Factors Survey 2 (PFS2) is completed within three days of referral
Children and family members with an **open in-home case, voluntary or court involved**	Assessment CPSW; Family Services CPSW; ISO Worker	CPSW sees family a minimum of one time monthly, typically more. Additionally, families often have a certified in-	SDM In-Home Risk Review is completed 2 weeks prior to each review hearing or at least every 6 months. Additionally, the SDM Safety Review is conducted anytime

		home services provider that is seeing them at least one time weekly.	there is a significant change within the family and prior to closing the case.
Children remaining in the **home with at least one sibling in placement**	Assessment CPSW; Family Services CPSW; ISO Worker	CPSW sees family a minimum of one time monthly, typically more. Additionally, families often have a certified in-home services provider that is seeing them at least one time weekly.	SDM In-Home Risk Review is completed 2 weeks prior to each review hearing or at least every 6 months. Additionally, the SDM Safety Review is conducted anytime there is a significant change within the family and prior to closing the case.
Pregnant and parenting youth in foster care	Assessment CPSW; Family Services CPSW; JPPO	CPSW or JPPO sees family a minimum of one time monthly.	The SDM Safety Assessment is completed within 24 hours of initial placement and Risk Reviews are conducted within 30-60 days of the assessment. For the duration of placement, the SDM Reunification Risk Review is performed within three months of removal date and two weeks prior to subsequent hearings or reunification.
Families with a **juvenile justice involved youth being served via an in-home case**	JPPO	JPPOs sees family 1-4 times monthly depending on SAVRY rating of low to high risk	^SAVRY is completed within 30 days of adjudication and conditional release and then re-administered every 6 months or at change of case status
Families with children who have been **recently reunified** and may be at risk of re-entry	Family Services CPSW; JPPO	CPSW or JPPO sees family a minimum of one time monthly	The SDM Risk Review is completed for court cases 2 weeks prior to each review hearing or at least every 6 months. Additionally, the SDM Safety Review is conducted anytime there is a significant change within the family and prior to closing the case.
Families with children who have been **recently adopted**	Post adopt CPSW	CPSW sees family a minimum of one time monthly	Some post-adopt families have an open in-home case. See above for informal assessment cadence

^SAVRY will be replaced with the CANS in January 2022

Staff will reassess, document, and make updates to the child's prevention plan throughout the life of the prevention case. This plan will be reviewed, every six months but could be more frequent given changes in the case. If at any point in time the safety or risk increases to a level where the child is no longer safe in the home, the case worker will take appropriate action to remove the child.

Section 6: Continuous Quality Improvement and Evaluation Strategy *(pre-print section 2; Attachment II)*

Evaluation Waiver Request for Well-Supported Interventions

The requirement for a formal evaluation may be waived if the intervention has been rated by the Title IV-E Prevention Services Clearinghouse as well-supported, there is compelling evidence in support of the effectiveness of the intervention, and CQI requirements are met. DCYF is requesting an evaluation waiver for five interventions that were rated well-supported by the Title IV-E Prevention Services Clearinghouse: Motivational Interviewing (MI), Healthy Families America (HFA), Homebuilders, Intercept, and Multisystemic Therapy (MST). CQI plans are aligned to the extent possible across interventions and include activities to monitor fidelity to the models and use the results of that monitoring to improve practice and measure the outcomes that are achieved. Please refer to Attachment II for each intervention's formal waiver request of an evaluation requirement for a well-supported practice (ACF PI 18-09 Attachment II).

Evidence to Justify an Evaluation Waiver for MST

The evidence in favor of the use of Multisystemic Therapy (MST) as a means of promoting positive youth behavior change and reducing the risk of foster care placements in New Hampshire is compelling.

First, MST has demonstrated effectiveness with target populations similar to New Hampshire's Family First target population. MST has been shown to be effective at improving conduct among youth and adolescents with behavior problems, including antisocial and violent behaviors (Henggeler et al., 1997; Jansen et al., 2013), justice system involvement (Schaeffer & Borduin, 2005; Weiss et al., 2013), and substance abuse (Henggeler et al., 1991). Knowing that child behavior problems contribute significantly to foster care entry in New Hampshire, MST is likely to improve youth outcomes and reduce foster care entries in the state. Moreover, New Hampshire is specifically targeting these populations through Family First. As described above, New Hampshire's target populations include children and youth who are involved with the Department of Juvenile Services who are at risk of entering an out of home placement, children with substance use disorders, and children with complex psychological or behavioral needs. Because of the alignment between the children and families for whom MST has been shown effective and the New Hampshire's Family First target population, MST particularly likely to be effective in New Hampshire.

Second, MST has demonstrated flexibility and favorable outcomes across diverse geographic locations and contexts. Studies have demonstrated the effectiveness of MST across a wide range of geographic locations globally and domestically. For example, studies have demonstrated

positive outcomes for MST in the Netherlands (Asscher et al., 2014), England (Fonagy et al., 2018), Norway (Ogden & Halliday-Boykins, 2004), and the United States (Johnides, Borduin, Wagner, & Dopp, 2017). MST has also been shown effective in a range of settings, including community mental health (Henggeler, Melton, Brondino, Scherer, & Hanley, 1997) and juvenile justice systems (Weiss et al., 2013). MST's effectiveness across geographic locations and contexts suggests its wide applicability and that it will also be effective in New Hampshire.

Last, MST possesses a particularly large body of literature pointing to its effectiveness. MST was rated "well-supported" as a Mental Health Program and as a Substance Abuse Program by the Title IV-E Prevention Services Clearinghouse. According to the IV-E Prevention Services Clearinghouse, 10 studies in 33 publications were rated high (7 studies in 27 publications) or moderate (3 studies in 6 publications) on research design and execution. These included favorable findings in outcomes related to:

- *Child permanency* (Henggeler et al., 2006; Vidal et al., 2017)
- *Child mental or emotional health* (Asscher et al., 2013; Asscher et al., 2014; Dekovic et al., 2012; Manders et al., 2013; Asscher et al., 2018; Jansen et al., 2013; Vermeulen et al., 2017; Weiss et al., 2013; Weiss et al., 2015; Fonagy et al., 2018; Fonagy et al., 2013; Ogden et al., 2006; Ogden et al., 2009; Ogden & Halliday-Boykins, 2004)
- *Child substance use* (Fonagy et al., 2013; Fonagy et al., 2018; Henggeler et al., 2006)
- *Child delinquency* (Henggeler et al., 1997; Scherer et al., 1994; Asscher et al., 2013; Asscher et al., 2014; Dekovic et al., 2012; Manders et al., 2013; Asscher et al., 2018; Jansen et al., 2013; Vermeulen et al., 2017; Borduin et al., 1995; Henggeler et al., 1991; Sawyer & Borduin, 2011; Schaeffer & Borduin, 2005; Wagner et al., 2014; Johnides et al., 2017; Klietz et al., 2010; Dopp et al., 2014; Dopp et al., 2017; Borduin et al., 1990; Mann et al., 1990; Butler et al., 2011; Cary et al., 2013; Vidal et al., 2017; Henggeler et al., 1992; Henggeler et al., 1993)

Taken together, this body of evidence justifies implementing MST as an intervention to reduce out-of-home care, improve behavioral and emotional functioning and reduce substance use among 12–17-year-olds in the target population.

Evidence to Justify an Evaluation Waiver for Homebuilders

Evidence suggests that Homebuilders has a high likelihood of effectiveness in New Hampshire.

First, research has demonstrated that Homebuilders can generate the specific outcomes New Hampshire aims to achieve through Family First. New Hampshire's Prevention Plan explicitly states that the state hopes to achieve increased child permanency and increased adult well-being. Studies have shown that participation in Homebuilders has yielded enhanced child permanency by preventing out-of-home placement directly after the intervention and at six and

twelve months out (Walton, 1993). Additional research found that Homebuilders also improved reunification and family stability at the conclusion of child welfare involvement (Walton, 1993; 1998). In addition to helping children, Homebuilders programming has had a positive impact on adult and family well-being outcomes, such as overall economic and housing stability and food security (Westat, 2002). Strong alignment between the proven outcomes of Homebuilders and New Hampshire's desired Family First outcomes suggests a high likelihood that Homebuilders will be successful in New Hampshire.

Second, Homebuilders has a track record of successfully serving children and families whose demographics and presenting challenges resemble those of New Hampshire's Family First target population. Homebuilders is designed to serve the families and youth that interact with the juvenile justice system, which is also a Family First target population for New Hampshire. Homebuilders works with their families to address problems that contribute to delinquency while allowing the youth to remain in the community. Staff help clients find the right school setting, attend classes regularly, adhere to curfews, comply with the court, participate in constructive activities with peers, and learn to manage anger and conflict without getting into trouble. Therapists also help parents learn to deal with the stress of raising an adolescent. Moreover, research from a Homebuilders implementation in Michigan has shown positive outcomes for justice-involved youth and their families (Kelly et al. 2021). Moreover, a rigorous study meeting the methodological standards of the Title IV-E Clearinghouse demonstrated Homebuilders' effectiveness in Utah, a state with similar demographic and geographic characteristics to New Hampshire (Walton et al, 1993). Utah and New Hampshire's child welfare systems both serve majority white populations, and both states are made up primarily of suburban and rural geography. Homebuilders' proven track record of demonstrating strong outcomes for children and families similar to those in New Hampshire's Family First target population suggests a high likelihood that Homebuilders will also be effective in New Hampshire.

Finally, the overall weight of evidence of Homebuilders' effectiveness contributed to the program's high likelihood of effectiveness in New Hampshire. The Title IV-E Prevention Services Clearinghouse has recently given a "well-supported" designation to the Homebuilders program as an In-Home Parent Skill-Based Service. Considering this designation for the level of research support for Homebuilders, DCYF submits this request for a waiver of the Family First evaluation requirement for consideration. The evidence in favor of the use of Homebuilders as a means of promoting successful family reunification and reducing the risk of out-of-home care is sufficiently compelling to warrant a waiver of the evaluation requirements for this model. According to the IV-E Prevention Services Clearinghouse, 2 studies in 7 publications were rated moderate on research design and execution. These included favorable findings in outcomes related to:

- *Child permanency* (Walton, 1993; Walton, 1998; Westat, 2002)
- *Caregiver economic and housing stability* (Westat, 2002)

Based on the research and how the model fits with the needs of the state, Homebuilders will prove to be effective in New Hampshire with the target population. Taken together, this body of evidence justifies implementing Homebuilders as an intensive intervention to reduce out-of-home care and stabilize families.

Evidence to Justify an Evaluation Waiver for HFA

The evidence in favor of the use of HFA as a means of promoting positive child and family outcomes in New Hampshire is compelling enough to warrant an evaluation waiver.

First, research has demonstrated that HFA can generate the specific outcomes New Hampshire aims to achieve through Family First. New Hampshire's Prevention Plan explicitly states that the state hopes to reduce maltreatment for families participating in the program: a decreased proportion of families with no new accepted DCYF referrals/assessments while enrolled in HFA, and no new founded maltreatment findings while enrolled in HFA. Studies have shown that participation in HFA contributes to a reduction in self-reports of maltreatment (Mitchell-Herzfeld 2005; Duggan 2004).

Second, HFA has demonstrated effectiveness with pregnant and parenting families with young children (Mitchell-Herzfeld 2005; Duggan 2004; Caldera 2007), which is also New Hampshire's HFA target population. As noted above, in New Hampshire HFA will be targeted to pregnant and parenting youth in care, aged 13-21, and pregnant women and new parents of children who are up to 24 months of age at enrollment. Family First identifies pregnant and parenting foster youth as a uniquely eligible population for preventative services, and several research studies demonstrate HFA's effectiveness with this population. As such, HFA's target population aligns well with the characteristics and needs of the children and families who will be served through Family First in New Hampshire.

Third, HFA's demonstrated efficaciousness in a wide variety of geographic locations suggests wide applicability and a high likelihood of effectiveness in New Hampshire. The Clearinghouse identifies a number of well-designed studies demonstrating the efficacy of HFA to cultivate and strengthen nurturing parent-child relationships, promote healthy childhood growth and development, and enhance family functioning by reducing risk and building protective factors in a variety of geographical locations, including Alaska (Duggan, Berlin, Cassidy, Burrell, & Tandon, 2009; Cluxton-Keller et al., 2014), Hawai'i (El-Kamary et al., 2004; BairMerritt et al., 2010; McFarlane et al., 2013), New York (Rodriguez, Dumont, Mitchell-Herzfeld, Walden, & Greene, 2010; Kirkland & Mitchell-Herzfeld, 2012; Lee, Kirkland, Miranda-Julian, & Greene, 2018), and Oregon (Green, Tarte, Harrison, Nygren, & Sanders, 2014; Green, Sanders, & Tarte, 2017; Green,

Sanders, & Tarte, 2018). HFA's effectiveness in this diverse array of geographic locations indicates the model's wide applicability and suggests that it is likely to also produce positive outcomes in New Hampshire.

Fourth, research on HFA has demonstrated the model's flexibility and favorable outcomes among children from various cultural backgrounds and with a variety of underlying problems, suggesting wide applicability. For example, Barlow et al.'s (2006) study assessing the impact of HFA on American Indian adolescents demonstrates that mothers in the intervention compared with mothers in the control group had significantly better outcomes, including higher parent knowledge scores and scoring significantly higher on maternal involvement scales. Blair-Merritt et al.'s (2010) work also demonstrates HFA's treatment effect among mothers who reported instances of intimate partner violence, concluding that those who received HFA services reported lower rates of physical assault victimization and significantly lower rates of perpetration relative to the control group. Lee et al. (2009) found HFA to be effective for families across a variety of cultural backgrounds by demonstrating HFA's effectiveness in reducing adverse birth outcomes among socially disadvantaged pregnant women, two-thirds of whom were Black or Hispanic. Based on HFA's well-established track record producing positive outcomes for children and families with diverse cultural backgrounds and underlying problems, it is likely that HFA will be effective among children in New Hampshire as well.

Last, the overall weight of evidence in favor of HFA's effectiveness contributes to the likelihood that it will be effective in New Hampshire. HFA was rated well-supported as an In-Home Parent Skill-Based Service by the Title IV-E Prevention Services Clearinghouse. The evidence in favor of the use of HFA as a means of promoting positive family dynamics and reducing the risk of foster care placements is compelling enough to warrant a waiver. The Clearinghouse identifies several well-designed studies demonstrating the efficacy of HFA to cultivate and strengthen nurturing parent-child relationships, promote healthy childhood growth and development, and enhance family functioning by reducing risk and building protective factors in a variety of geographical locations. According to the IV-E Prevention Services Clearinghouse, six studies in 36 publications were rated high or moderate on research design and execution. These included favorable findings in outcomes related to:

- *Child safety* (Duggan et al., 2004; Mitchell-Herzfeld et al., 2005)
- *Child behavioral and emotional functioning* (Caldera et al., 2007; Duggan et al., 2005),
- *Child cognitive functioning* (Caldera et al., 2007)
- *Parenting practices* (DuMont et al., 2008)
- *Parent/caregiver mental or emotional health* (Duggan et al., 2004; Duggan et al., 2007; McFarlane et al., 2013)

- *Family functioning* (Bair-Merritt et al., 2010)

In addition, the Home Visiting Evidence of Effectiveness (HomVEE) review, which was funded by the U.S. Department of Health and Human Services, identified HFA as meeting the criteria established by HHS for an "evidence-based early childhood home visiting service delivery model." Five moderate to high quality impact studies were found to favorable effects on positive parenting practices (Duggan et al., 1999; LeCroy & Krysik, 2011; Caldera et al., 2007; Duggan et al., 2007; Green et al., 2014) and six were found to have favorable effects on Reductions In Child Maltreatment (Duggan et al., 2004; Duggan et al., 2007; Dumont et al., 2008; Dumont et al., 2010; Green et al., 2017; Landsverk et al., 2002). Taken together, this body of evidence justifies implementing HFA as an intervention to reduce out-of-home care and stabilize families.

Lastly, in September 2018, Healthy Families America implemented a child welfare protocol. Programs that choose to implement the child welfare protocol can enroll families referred by the child welfare system up until the child is 24 months old rather than 3 months old (Healthy Families America, 2018). HFA local sites have to receive national office approval to utilize this adaptation. New Hampshire is contractually requiring that all local HFA sites receive national office approval, if they haven't already, so that each site can provide the child welfare protocol adaptation of HFA. Services delivered under the child welfare protocol to child welfare system-involved families are identical to the services delivered to other families. The only difference is that families referred by the child welfare system can be enrolled up until the child is 24 months old.

While there have not been any specific studies or evaluations published to date that specifically focus on the child welfare adaption of Healthy Families America, Easterbrooks and colleagues conducted a randomized controlled trial of 704 first-time mothers in Massachusetts, a neighboring state to New Hampshire. The mothers were either provided with the HFA service or another community service. The outcome variable were future maltreatment reports up to a mean age of 7 years old. This is particularly relevant given the child welfare protocol can be provided up until 5 years of age. Of the 52% of families who experienced initial CPS reports, 53% experienced additional CPS reports. Children of mothers in the home visiting group were less likely to receive a second report and had a longer period of time between initial and second reports (Easterbrooks, Kotake, and Fauth, 2019). Specifically, this study concluded that use of the home visiting program reduced the recurrence of CPS maltreatment reports by 32% and increased the length of time between initial and additional CPS reports.

HFA's effectiveness in preventing further child maltreatment in the 0-5 age range makes it a very unique, compelling and impactful prevention service in support of NH's overall family strengthening and prevention strategy.

Evidence to Justify and Evaluation Waiver for MI

DCYF seeks an evaluation waiver for MI due to the compelling evidence suggesting that MI will be effective in New Hampshire.

First, research has demonstrated that MI improves treatment outcomes of parents who have substance use disorders. Caregivers with substance use disorders represent a key MI target population in New Hampshire, and reducing substance misuse is a key outcome New Hampshire aims to impact through implementation of MI. Because parent/caregiver substance use has consistently been the single a significant family stressor in founded allegations of abuse in New Hampshire (54% in FY2019), MI is likely to be effective with the target population in New Hampshire (NH Department of Health and Human Services, 2020a). DCYF believes that MI will improve treatment outcomes for parents with substance use disorders and, as a result, will prove effective in reducing the risk of foster care placements of children whose parents are affected by substance use. According to the IV-E Prevention Services Clearinghouse, 15 studies were rated high or moderate on research design and execution and included favorable findings on caregiver substance abuse outcomes (Carey, 2006; Diaz Gomez, 2019; Fernandez, 2019; Field, 2010; Field, 2014; Freyer-Adam, 2008; Fuster, 2016; Gaume, 2011; Gentilello, 1999; Hansen, 2012; Marlatt, 1998; Rendall-Mkosi, 2013; Roy-Byrne, 2014 Saitz, 2007; Saitz, 2014; Stein, 2011).

Since information in the Title IV-E and CEBC curations were last updated, more recent reviews have also been published. The most recent appears to be the review published by Hall et al. (2020). Nineteen studies met criteria for inclusion in the review. Of those 19 studies, 11 studies provided information about the effectiveness of MI as a treatment. Three (3) of the five studies examining MI as a stand-alone treatment (Carroll et al., 2001; Forrester et al., 2008; and Forrester et al., 2018) and all six of the studies examining MI adjunctive to other treatments (Chaffin et al., 2009; Chaffin et al., 2011; Schaefer et al., 2013; Runyon et al., 2009; and Porter and Howe, 2008) reported results in favor of MI.

Three of the five studies examining MI as a stand-alone treatment reported results in favor of MI (Carroll et al., 2001; Forrester et al., 2008; and Forrester et al., 2018) examined substance use treatment uptake among a sample of parents in child welfare who had been referred for substance use evaluations. Participants randomly assigned to receive the MI- informed evaluation were significantly more likely to attend a subsequent treatment session than those randomized to receive a standard evaluation.

Furthermore, these studies provide compelling support for MI in child welfare generally and for New Hampshire's specific plan to use MI adjunctive to other EBPs more specifically. For example, Schaeffer et al. (2013) provides direct support for New Hampshire's plan to use MI adjunctive to

MST. Furthermore, there is evidence that MI is beneficial when combined with PCIT (Chaffin et al., 2009; Chaffin, Funderburk, Bard, & Valle, 2011).

MI also shows significant evidence of effectiveness as an intervention to enhance engagement in services (Lundahl et al., 2010)—a key desired outcome of implementing MI in New Hampshire. MI also appears to improve outcomes in a variety of domains when added to other treatment approaches (Hettema, Steele, & Miller, 2005). In addition to using MI as an integrated component of case management for families served by the CBVS agencies, New Hampshire intends to train all Child Protective Services and Family Preservation Service workers in MI to increase the number of families who participate in a broad range of services to prevent child removal. We anticipate that MI will augment both CBVS and CPS core practice skills of engagement and teaming with families to ensure appropriate planning and service matching and promote service engagement.

Additionally, MI has been proven effective through a particularly large body of literature and with diverse target populations. MI is currently rated as "well supported" by the Title IV-E Prevention Services Clearinghouse as a Substance Abuse intervention following review of 75 eligible studies that indicated favorable effects in the target outcomes of adult well-being. MI is also rated "well supported" by the California Evidence-based Clearinghouse (CEBC) as both a Substance Abuse intervention and Motivation and Engagement program. The CEBC provides reference to four large, systematic reviews and meta-analyses summarizing existing literature on the effectiveness of MI (Burke, Arkowitz, & Menchola, 2003; Hettema, Steele, & Miller, 2005; Vasilaki, Hosier, & Cox, 2006; and Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010). MI has been demonstrated effective in a wide range of contexts, including engagement of families in comprehensive assessments (Snyder et al., 2012), juvenile corrections (Doran et al., 2013), and child protection work (Forrester et al, 2008). MI has also shown effectiveness in producing a wide range of outcomes, including improved oral health behaviors (Kay et al., 2018), diet and exercise (Martins & McNeil, 2009), and cognitive and behavioral change among domestic violence offenders (Kistenmacher & Weiss, 2008). The exceptionally large body of literature demonstrating MI's effectiveness, as well as the diverse contexts and outcomes demonstrated in the research, suggest that MI is widely applicable and likely to be effective in New Hampshire if practiced with fidelity.

Last, New Hampshire's provider community has a track record of successfully implementing MI. Currently New Hampshire offers MI services in several community organizations across the state including the North County Health Consortium and New Hampshire Recovery Coach Academy. While research evidence does not exist regarding MI's effectiveness in these settings, both organizations have a track record serving New Hampshire families and youth and continue to invest in building capacity to deliver the model.

Evidence to Justify an Evaluation Waiver for Intercept

DCYF seeks an evaluation waiver for Intercept due to the compelling evidence suggesting that Intercept will be effective in New Hampshire.

New Hampshire DCYF asserts that the confirmation of Intercept's effectiveness is both a) evident and b) compelling. Intercept is rated as a well-supported practice on the Title IV-E Prevention Services Clearinghouse (the Clearinghouse). As described on the Clearinghouse's website, "Intercept is rated as a well-supported practice because at least two studies with non-overlapping samples … achieved a rating of moderate or high on design and execution and demonstrated favorable effects in a target outcome domain."[1]

Intercept's evidence is also compelling as reflected by the evaluations reviewed by the Clearinghouse. The Clearinghouse shows that Intercept had favorable[2] and statistically significant impacts on child permanency, as evidenced by a reduction in out-of-home placements[3] and an increase in planned permanent exits[4]. In a study conducted by the Center for State Child Welfare Data at Chapin Hall, Intercept was shown to reduce the chance of out-of-home placement by 53% following a maltreatment investigation. In Chapin Hall's follow-up evaluation with a non-overlapping population of youth the risk of placement was 37% lower among children referred to Intercept than the children in the comparison group. The effect of Intercept is sustained at six and 12 months after Intercept services end. In addition, another study by Chapin Hall, compared to a matched comparison group, after controlling for how long they were in care, the odds of achieving permanency were approximately 24% higher for the Intercept group. A safe reduction in the number of youth in out-of-home placements and an increase in the number of young people achieving permanency are key outcomes in New Hampshire's prevention service array. This is emphasized in New Hampshire's Prevention Plan as it explicitly states that the state hopes to achieve increased child permanency and increased adult well-being. Additionally, Intercept has a track record of successfully serving children and families whose demographics and presenting challenges resemble those of New Hampshire's Family First target population. Intercept is also designed to serve the families and youth that interact with the juvenile justice system, which is also a Family First target population for New Hampshire.

[1] Title IV-E Prevention Services Clearinghouse. Intercept. https://preventionservices.abtsites.com/programs/331/show

[2] Defined in the Title IV-E Prevention Services Handbook of Standards and Procedures as statistically significant and in a desired direction.

[3] Huhr, S., & Wulczyn, F. (2020a). Do intensive in-home services prevent placement?: A case study of Youth Villages' Intercept® program. The Center for State Child Welfare Data.

[4] Huhr, S., & Wulczyn, F. (2020b). Do intensive in-home services promote permanency?: A case study of Youth Villages' Intercept® program. The Center for State Child Welfare Data.

It should also be noted that according to the Clearinghouse's review, Intercept produced multiple "favorable" impacts on outcomes, with zero noted as "no effect" or "unfavorable" impacts. A summary of this review's findings can be found in Table 6 below.

Table 6: Intercept Summary of Findings[5]

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child permanency: Out-of-home placement	0.40 15	2 (2)	91778	Favorable: 2 No Effect: 0 Unfavorable: 0
Child permanency: Planned permanent exits	0.13 5	1 (1)	4029	Favorable: 1 No Effect: 0 Unfavorable: 0

DCYF Continuous Quality Improvement (CQI) Structure

DCYF's work to enhance and elevate our service array to strengthen and preserve families is grounded in research and data in child welfare. New Hampshire has a strong staff base of CQI reviewers and trained quality assurance staff. DCYF strives to build CQI capacity among staff by integrating CQI activities into daily practice and collaborating with service providers.

The backbone of the CQI system at DCYF centers around ongoing case practice reviews (CPR) and active contract management (ACM). Given that prevention services and programs are procured through contracts with DCYF, both processes will be adapted to support Family First quality improvement activities. The CPR process mirrors the Child and Family Services Reviews ensuring random sampling and use of a standardized tool. The Administration for Children and Families' (ACF) CFSR framework and Online Monitoring System (OMS) tools are fundamental instruments used to review New Hampshire child protective and juvenile justice services. The case review process is an integral component of performance measurement and accountability throughout DCYF.

The ACM framework is composed of three guiding principles: identifying key data, generating insights, and driving action toward improvement. Key components of active contract

[5] Title IV-E Prevention Services Clearinghouse. Intercept. Summary of Findings. https://preventionservices.abtsites.com/programs/331/show

management include frequent, collaborative meetings in which data on key outcome indicators will be shared. Additionally, the ACM team provides a deeper dive into analysis on critical performance improvement topics, which support the team in making operational changes based on those insights. Used informally, yet frequently for practice improvement in this context is the Plan-Do-Study-Act (PDSA) Cycle approach. DCYF Field Administrators are creative and often pilot small practice changes in district offices with this model.

CQI Roles & Responsibilities

To ensure a comprehensive framework, DCYF's CQI activities will be an intra-divisional effort. Working together, the Bureau of Community, Family and Program Support, the Bureau of Evaluation, Analytics, and Reporting, and the Bureau of Professional and Strategic Development will develop and implement specific CQI strategies for each program model. The roles and responsibilities of the various teams and partners who will execute our CQI strategies will differ according to the service model. However, we have identified several key roles that will be owned by one or more entries during the implementation of our well-supported interventions.

In general, the groups of DCYF and partner organizations who will work together and share these roles and responsibilities include:

- *DCYF Bureau of Community, Family, and Program Support:* Primarily responsible for coordinating various aspects of the CQI strategy and providing the monitoring and management of the prevention interventions.
- *DCYF Bureau of Evaluation, Analytics, and Reporting:* Primarily responsible for the analysis of data that helps feed various roles/functions that comprise the CQI process.
- *DCYF Bureau of Professional and Strategic Development:* Primarily responsible for training and support of the field practices that advance the goal of high quality and consistent service referrals and delivery across NH.
- *Contracted provider organizations:* Primarily responsible for implementing the various CQI strategies in coordination with DCYF. These responsibilities will include collaborating with DCYF and the provider community on operationalizing the CQI processes, collecting and reporting relevant fidelity and outcome reporting data, and performing activities designed to support performance improvement.
- *Model developers/certified trainers:* Primarily responsible for providing some of the ongoing data reporting as well as training and coaching to support fidelity monitoring and quality improvement.

DCYF CQI Strategy for Well-Supported Interventions

A consistent, statewide CQI strategy will be utilized to monitor fidelity to the interventions and track outcomes across the four well-supported models. As part of DCYF's active contract management (ACM) framework, quarterly CQI meetings will be held with provider and DCYF stakeholders to review data reports, plan and monitor improvement goals, and address challenges identified by stakeholders. Quantitative data will be collected and aggregated from several sources, including DCYF's state SACWIS system known as Bridges (and eventually its CCWIS aka Granite Families), model specific databases, and the provider agencies' case management systems of record. CQI processes will also include periodic case reviews conducted with providers to supplement quantitative data.

DCYF is currently developing increased capacity around service delivery, service matching and referrals, and contract management. FFPSA funds have been utilized to expand the number of staff involved in service-related activities, and a "Service Array Unit" has been created. This five-person team (four service array specialists and one administrator) will be the conduit between EBP service providers and DCYF field staff and will be working with EBP providers to monitor performance. Service Array team members are assigned to monitor performance for specific contracts and will be utilizing increased skill regarding contract management. Active Contract Management (ACM) is a process that DCYF has been developing through technical assistance from the Harvard Government Performance Lab (Harvard GPL). Part of the technical assistance is supporting the Service Array team members in not only contract management, but developing their capacity around providing coaching, guidance, and technical support to DCYF field staff. This will evolve over time, but initially will focus on areas related to service implementation, matching, referrals and other technical aspects that pertain to accessing these services.

DCYF's Service Array team is built on a regional model, and CQI data/performance outcomes are going to be communicated to regional offices via this model. DCYF's data team and field services administration play a role in this, but Service Array Unit members will be the primary resource for field staff to access information on service effectiveness and utilization. DCYF will hold regular meetings to share outcomes between EBP providers and local DCYF leadership.

To further ensure compliance and promote coordination, DCYF will add participation in CQI processes, quarterly meetings, case reviews, and focus groups to provider contracts in state fiscal year 2022. Providers will also be expected to complete intervention specific fidelity monitoring, as prescribed by each individual model's implementation manual or purveyor. In the sections that follow are more specifics on each model's quality improvement strategy.

Multisystemic Therapy-Specific CQI Strategy

While DCYF will begin to fund MST starting in 2021, DCYF is committed to performance measurement and continuous improvement as a central part of our partnership with the MST providers in the years to come. In the quarterly meetings, findings will be discussed with an eye to ensuring quality implementation and identifying changes to improve implementation and outcomes.

To feed the CQI plan for this intervention, DCYF will coordinate with MST Services, Inc. and provider agencies to regularly produce and monitor programmatic data. The sources for this information will include the provider agencies' case management systems, SACWIS data from Bridges, as well as MST Services' QA/QI data system.

There is considerable information about MST's quality assurance program in the public domain (MST Services, Inc, 2020). The MST QA/QI system provides mechanisms at each level (therapist, supervisor, expert/consultant, and program) for training and support on the elements of the MST treatment model, measuring implementation of MST, and improving delivery of the model as needed. By providing multiple layers of clinical and programmatic support and ongoing feedback from several sources, the system aims to optimize favorable clinical outcomes through therapist and program level support and adherence. Measurement of the implementation of MST is a function of the MST Institute and is intended to provide all MST programs around the world with tools to assess the adherence to MST of therapists, supervisors, experts, and organizations. Research results have indicated that when therapists, supervisors and experts adhere closely to the treatment model, outcomes are better for families. After reviewing MST's fidelity measures, DCYF has selected a subset of these measures to include in its CQI plan alongside other proposed process and outcome indicators. To this end, the Family First CQI strategy for MST will be driven by the following questions and performance measures:

- *Are children and families in the target population being referred to MST?*
    - Proportion of eligible children who were referred to MST, overall and by district office.
- *Are children and families in the target population enrolling in MST once they are referred?*
    - Proportion of referred children who are enrolled.
- *Is enrollment occurring in a timely manner?*
    - Proportion of referred children who receive a face-to-face within three days of referral.
- *What is the duration and intensity of their MST service involvement?*
    - Average number of sessions/contacts received per month of enrollment.
- *Is service engagement consistent with the MST model?*

- Average scores for the subscales for satisfaction and adherence on the Therapist Adherence Measure (TAM).

- *How often do children complete the program?*
  - Proportions of children who do and do not complete the program (incl. reason for non-completion).
  - Proportion of children who "successfully" complete the program per MST discharge criteria (typically defined as successfully completing the majority of goals within the child's individual service plan).

- *What is short- and long-term impact on outcomes due to MST participation?*
  - Proportion of children who commit new offenses while enrolled in MST.
  - Proportion of children with probation violations filed while enrolled in MST.
  - Proportion of children who are placed into shelter care/another type of short-term care while enrolled in MST.
  - Proportion of children with a new case opened to JJS within six months after program discharge.
  - Proportion of children who enter any form placement within six months after program discharge, including foster care.
  - Proportion of children with a case opened to JJS within 12 months of program discharge.
  - Proportion of children who enter any form of placement within 12 months of program discharge, including foster care.

- *Are we equitably serving referred children to this program?*
  - Relative rate of children enrolled by racial/ethnic and geographic characteristics

Homebuilders-Specific CQI Strategy

Homebuilders will be continuously monitored to ensure fidelity to the practice model and achievement of outcomes. Like MST, Homebuilders will be launched in 2021 or 2022 as a new DCYF-funded service. Eligible families will include those with children (birth to 18) at imminent risk of foster care placement across the candidacy subgroups. Families typically receive four to six weeks of intensive intervention, with up to two "booster sessions." Therapists typically serve two families at a time and provide 80 to 100 hours of service, with an average of 45 hours of face-to-face contact with the family.

The DCYF Bureau of Community, Family, and Program Support will actively and regularly convene with providers on no less than a quarterly basis as part of a performance-focused active contract management (ACM) framework. To prepare for these meetings, the team will review quantitative and qualitative data to assess implementation, track fidelity to the model, and

assess child and family outcomes. The sources for this information will include the provider agencies' case management systems, SACWIS data from Bridges, as well as the Homebuilder's QUEST data system. QUEST is designed to assure quality through the development and continual improvement of the knowledge and skills necessary to obtain model fidelity and service outcomes. QUEST activities focus on providing training and creating an internal management system of ongoing evaluation and feedback (Institute for Family Development, 2014). After reviewing Homebuilders' fidelity measures, DCYF has selected a subset of these measures to include in its CQI plan alongside other proposed process and outcome indicators. To this end, the Family First CQI strategy for Homebuilders will be driven by the following questions and performance measures:

- *Are children and families in the target population being referred to Homebuilders?*
    - Proportion of families who are referred to Homebuilders.

- *Are children and families in the target population enrolling in Homebuilders once they are referred?*
    - Proportion of referred families who are enrolled.

- *Is enrollment occurring in a timely manner?*
    - Average time to enrollment from the time and date of referral.
    - Proportion of families who meet with a therapist within 24 hours of the time of referral.

- *What is the duration and intensity of their Homebuilders service involvement?*
    - Proportion of families receiving at least treatment sessions and a service plan.
    - Average number of sessions/contacts received per month of enrollment.
    - Proportion of families who meet with their therapist at least three times per week.
    - Proportion of families who have more than 38 hours or more of face-to-face contact (excluding interventions that close prematurely).

- *How often do children complete the program?*
    - Proportion of families who complete at least 10 hours of treatment sessions (minimal completion).
    - Proportion of families who complete at least 40 hours of treatment sessions (full completion).

- *What is the level of coordination between the Homebuilders provider (and its locations) and the relevant DCYF staff?*
    - Proportion of positive responses to the question: "Did you have adequate contact with the therapist?" on the Homebuilders Referent Feedback Survey.

- *What is short- and long-term impact on outcomes due to Homebuilders participation?*
    - Proportion of families (individuals) with no new accepted DCYF referrals/assessments while enrolled in Homebuilders.
    - Proportion of families (individuals) with no new founded maltreatment findings while enrolled in Homebuilders.
    - Proportion of families who are placed into shelter care/another type of short-term care while enrolled in Homebuilders.
    - Proportion of families with children who enter any form placement within six months after program discharge, including foster care.
    - Proportion of families who enter any form of placement within 12 months of discharge, including foster care.

- *Are we equitably serving referred families to this program?*
    - Relative rate of families enrolled by racial/ethnic and geographic characteristics.

HFA-Specific CQI Strategy

Given its oversight of the MIECHV Program's CQI plan for local implementing agencies (LIAs) in New Hampshire, the Division of Public Health Services (DPHS) will continue to be an important collaborator for Family First's implementation of this model. The current MIECHV infrastructure that will be leveraged to monitor DCYF-referrals will include the use of internal and potentially contracted CQI staff to support CQI efforts across the implementing providers. Presently, CQI coaching is provided to support each LIA in developing and successfully executing CQI projects and achieving their individual CQI goals. The role of the CQI coach assists providers in examining data entry practices and data reports to ensure appropriate monitoring, and program improvement through Plan, Do, Study, Act (PDSA) cycles.

On a monthly basis, the providers then come together virtually to share lessons learned and best practices from their CQI projects, often with a spotlight on a particular agency that has made strides in the area being reviewed. While each agency may have a different focus for their CQI project, all providers are responsible for examining their own data for alignment to the HFA Best Practice Standards (BPS) as well as 19 federally defined performance measures.

In addition to receiving monthly reports from the providers on their current capacity, DPHS also receives quarterly data to measure contract deliverables. Following submission of these monthly and quarterly reports, the DPHS Program Manager reviews the reports and provides feedback in a timely manner to each of the providers. If a particular performance measure goal is not met, agencies are required to identify what caused the deficit, and develop a plan for addressing the shortfall.

Fidelity to the HFA model is monitored by DPHS through the completion of annual sub-recipient monitoring site visits. During these site visits, a case or several cases is/are reviewed utilizing HFA's Family and Supervision Checklist document to review a particular case for various components required by the HFA BPS. This annual review serves the purpose of preventing "model drift" between the 4 years from one HFA accreditation to the next reaccreditation. During these site visits, a fiscal review is also conducted to ensure adequate "braiding" of program funds in addition to ensuring expenditures are reasonable, allowable, and allocable per the MIECHV program's guiding statute 45 CFR 75. Additionally, different aspects of the HFA BPS are reviewed approximately every other month during HFA Supervisor Meetings to ensure continued attention to and awareness of the various intricacies of the BPS.

DCYF is currently collaborating with DPHS to adopt its CQI performance measures for the child welfare adaption of the model for child welfare referrals. Although additional planning will be required to ensure appropriate cross-system data sharing, the Family First CQI strategy for HFA is aiming to address the following questions and performance measures:

- *Are children and families in the target population being referred to and enrolled in HFA?*
    - Proportion of families who are referred to HFA from DCYF.
      Proportion of DCYF-referred families that were enrolled between 3 and 24 months of age.

- *Is enrollment occurring in a timely manner?*
    - Average time to enrollment from the time and date of referral.

- *What is the duration and intensity of their HFA service involvement?*
    - Proportion of families that are retained in the program over specified periods of time (6 months, 12 months, 24 months, 36 months, etc.) after receiving a first home visit.
    - Proportion of families who receive at least seventy-five (75%) percent of the appropriate number of home visits based upon the individual level of service to which they are assigned.

- *How often do children complete the program?*
    - Proportion of families that discharged who completed a minimum of 3 years of service.

- *What is short- and long-term impact on outcomes due to HFA participation?*
    - Proportion of families with no new accepted DCYF referrals/assessments while enrolled in HFA.

- Proportion of families with no new founded maltreatment findings while enrolled in HFA.
- Proportion of families who enter any form of placement within 12 months of discharge, including foster care.

- *Are we equitably serving referred families in this program?*
  - Relative rate of families enrolled by racial/ethnic and geographic characteristics.

The data sources for these performance measures will include the provider agencies' case management systems, Social Solutions Efforts to Outcome (ETO) data system, and data from DCYF Bridges. Current planning efforts between DCYF, DPHS, and the providers will be required prior to developing a new HFA request for proposals in early 2022 and a rollout of services in the fall of 2022. This RFP will seek to secure additional capacity for Family First-funded slots and require enhanced data collection, a data sharing agreement and quality improvement efforts.

Motivational Interviewing-Specific CQI Strategy

Given that MI is a new practice for the CBVS program, DCYF sought support from its MI trainer to standardize practice and establish fidelity standards and measures. It should be noted there are no adaptations to the original model, and it is presently being implemented in alignment with the model handbook as noted on the Title IV-E Prevention Services Clearinghouse.

For fidelity monitoring, the CBVS providers will use the Motivational Interviewing Treatment Integrity (MITI) instrument, which yields feedback that can be used to increase clinical skill in the practice of MI and measures how well a practitioner is using MI. The MITI is the most commonly used tool to evaluate the fidelity of MI is the Motivational Interviewing Treatment Integrity (MITI) coding system (Moyers, Martin, Manuel, Hendrickson, & Miller, 2005). Originally created as a research tool, the MITI has proved useful in clinical settings where rigor in supervision and evaluation is needed (Manuel & Drapkin, 2015).

Every six months, CBVS training staff will use the MITI to review at least one family from the caseload of each specialist during a visit. Families will be chosen at random. Coded scores on MITI assessment will be completed and maintained ongoing to assess changes in skill over time. Scores, along with additional notes by the trainer, will be reviewed every six months to ensure fidelity to the model and to develop change activities that support the continued successful implementation of MI.

As part of its Active Contract Management (ACM) CQI framework, the DCYF ACM teams and CBVS staff will then review MITI scores as well as other quantitative data on a periodic basis to assess implementation, track fidelity to the model, and assess child and family outcomes. In these meetings, findings will be discussed to identify needed shifts in practice to improve

implementation and outcomes. During this initial phase of implementation, the DCYF ACM team will use data to answer the following research questions and indicators in its ongoing CQI plan:

- *Are children and families in the target population being referred to and enrolled in CBVS?*
    - Proportion of eligible families who were referred to CBVS, overall and by district office.

- *Is enrollment in CBVS occurring in a timely manner?*
    - Average time to enrollment from the date of DCYF referral.

- *Once enrolled in CBVS, are children and families being referred to other direct services and supports?*
    - Proportion of families who are referred to other direct services by service category.
    - Average time from the date of referral to first date of direct service provision by service category.

- *What is the duration of their participation with CBVS and other direct services?*
    - Average duration of families' involvement with CBVS program.
    - Average duration of families' involvement with other direct services.

- *What is the fidelity to the MI model?*
    - Average scores by domain on the MITI.

- *What is short- and long-term impact on outcomes due to provision of MI and participation in CBVS?*
    - Difference between initial and follow-up scores on the Protective Factors Survey-version 2 (PFS-2).
    - Proportion of families (individuals) with no new accepted DCYF. referrals/assessments while enrolled in CBVS.

- *Are we equitably serving referred families?*
    - Average duration of program involvement with CBVS by racial/ethnic and geographic characteristics.
    - Average duration of involvement with other direct services by racial/ethnic and geographic characteristics.

Intercept-Specific CQI Strategy

Intercept will be continuously monitored to ensure fidelity to the practice model and achievement of outcomes. Eligible families will include those with children (birth to 18) at imminent risk of foster care placement across the candidacy subgroups. Families typically receive four to six months of intensive intervention. Family Intervention Specialists typically serve four to six families at a time.

While DCYF will begin to fund Intercept starting in 2022, DCYF is committed to performance measurement and continuous quality improvement as a central part of our partnership with Youth Villages and their Intercept staff in the years to come. In the quarterly, at minimum, contract management meetings, findings will be discussed with an eye to ensuring quality implementation and identifying changes to improve implementation and outcomes.

Since Youth Villages' implementation of its Intercept model, Intercept has maintained fidelity to the model. Continuous quality improvement is incorporated throughout the Intercept model, with specific fidelity measures tied to high-quality service delivery that lead to sustainable, positive long-term outcomes for children and families. The Intercept CQI framework is based on three primary processes that are internal to or influence the program model.

- **Program Model Reviews**: The program model review (PMR) is Youth Villages' primary process for monitoring the implementation of the Intercept model. Annually in each location, the PMR gathers data through documentation review, customer surveys, staff surveys, interviews, and aggregate data pulled from the electronic health record. This review generates scores that indicate areas of strength and opportunities for improvement to help ensure that the program meets the expected outcomes. Following the identification of areas that need to be addressed, clinical and operational leadership work with the evaluation team to create a plan for additional monitoring and/or evaluation activities that will support implementation improvement. These monitoring and/or evaluation activities follow the same process/format as PMR with a more narrow focus (e.g., monitoring quality and timeliness of a specific set of documents) as well as a shorter timeframe.
- **Performance Management**: In addition to the Intercept model's clinical consultation and group supervision processes, Youth Villages regularly reviews key performance indicators such as caseloads, staff retention, and rates of serious incidents to monitor the program's performance. The regular review of these measures gives leadership a regular, consistent look at whether the program is operating "within the guardrails".

Ongoing Outcome Evaluation: Youth Villages developed an internal evaluation process to collect data at admission, discharge, and 12-months post-discharge to provide the agency with information used for program monitoring and improvement. All youth who receive at least 60 days of service are followed at all post-discharge points, regardless of status at discharge. Data

are collected on placement, custody, school status, negative involvement with the justice system, and out-of-home placements.

As part of its Active Contract Management (ACM) CQI framework, the DCYF ACM teams and Intercept staff will review the qualitative and quantitative data mentioned above on a periodic basis to assess implementation, track fidelity to the model, and assess child and family outcomes. In these meetings, findings will be discussed to identify needed shifts in practice to improve implementation and outcomes. During this initial phase of implementation, the DCYF ACM team will use data to answer the following research questions and indicators in its ongoing CQI plan:

- *Are children and families in the target population being referred to Intercept?*
    - Proportion of families who are referred to Intercept.

- *Are children and families in the target population enrolling in Intercept once they are referred?*
    - Proportion of referred families who are enrolled.

- *Is enrollment occurring in a timely manner?*
    - Average time to enrollment from the time and date of referral.
    - Proportion of families who meet with Intercept staff within 3 days of referral.

- *What is the duration and intensity of their Intercept service involvement?*
    - Average number of sessions/contacts received per month of enrollment.
    - Proportion of families who meet with their Family Intervention Specialist at least three times per week.

- *How often do children complete the program?*
    - Share of families who do/do not complete the program (incl. reason for non-completion)
    - Share of children and families who have shown a reduction in referral behaviors and/or challenges following their discharge from Intercept®, with respect to the minimum 60 days of service.

- *What is the level of coordination between the Intercept staff and the relevant DCYF staff?*
    - Proportions of families offered the "Family Satisfaction Survey" at the conclusion of every case discharge, and again at 12 months post-discharge in order to use the findings to improve the Intercept® program and its outcomes.
    - Weekly summary reports and monthly progress reports for DCYF field staff.
    - Participating in team meetings, to include the DCYF field staff and family, at least every six (6) weeks.

- *What is short- and long-term impact on outcomes due to Intercept participation?*

- Proportion of families (individuals) with no new accepted DCYF referrals/assessments while enrolled in Intercept.
- Proportion of families (individuals) with no new founded maltreatment findings while enrolled in Intercept.
- Proportion of families with children who are placed into foster care, kinship care or congregate while enrolled in Intercept.
- Proportion of families with children who enter any form placement within six months after program discharge, including foster care.
- Proportion of families who enter any form of placement within 12 months of discharge, including foster care.

- *Are we equitably serving referred families to this program?*
  - Relative rate of families enrolled by racial/ethnic and geographic characteristics.

Section 7: Child Welfare Workforce Training and Support *(pre-print section 5)*

DCYF Staff Training

Founded from the belief that ongoing learning is a critical systemic factor in achieving quality outcomes for children and families, DCYF created the Bureau of Professional and Strategic Development (BPSD). The Bureau ensures that partnerships (including state and contracted agencies) provide collaboratively designed, innovative, and engaging learning opportunities consistent in supporting best practice, and DCYF's practice model. In collaboration with BPSD, staff professional development is provided through the Child Welfare Education Partnership (CWEP) at Granite State College. All new direct service staff involved with Family First will have completed the DCYF Core Academy Training within the first six months and up to one year of employment. Core Academy is a specific experiential competency-based learning series that includes a capstone project.

DCYF has established a structured mentoring program to ensure a comprehensive transfer of learning as the staff begin their new role. The mentoring program is in addition to shadowing that occurs during training and weekly supervision. The goal of mentoring is to familiarize the new staff with procedures, policies, best practice, and the culture and Practice Model of DCYF. Mentoring at DCYF is an integrated component of the pre-service training program to ensure a more meaningful transfer of learning experience for new staff. All staff have shadowing experiences as they relate to the DCYF system, offices, skill development, and an ability to demonstrate learning in key areas. This mentoring will play a larger role as staff will need to demonstrate to their Field Practice Advisor an ability to complete certain tasks.

CWEP also provides a Supervisor Core Academy to equip supervisors for their role in supporting the direct service staff. In addition to pre-service training, all full-time direct practice staff must

complete 30 hours of annual training. The DCYF SACWIS (aka Bridges) allows each staff person to track their own training credits, and their supervisors have access to each member of their unit's training hours. Opportunities for ongoing training are listed at the CWEP. To ensure compliance, DCYF monitors the training plan through the Annual Progress and Services Report (APSR) that is submitted to the federal government annually.

As described in Section 3, several modules within this core curriculum provide education about the impact of trauma on the child and family and teaches skills to ensure that worker engagement, advocacy, assessment, and service planning are aligned to these needs. In addition to the core curriculum, the CWEP offers access to various other trauma-informed care training resources that can be leveraged to increase competency.

As part of FFPSA implementation, staff and supervisors who work with the specific candidacy subpopulations will receive additional required training to cover the new requirements associated with Family First target populations. These trainings will focus on 1) identifying appropriate candidates for prevention services through the use of the SDM Safety Assessment, SDM Risk Assessment, and CANS; 2) matching candidates to the appropriate evidence-based intervention(s); 3) developing and evaluating the child-level prevention plan; 4) monitoring ongoing safety through formal and informal assessment; and 5) ensuring data practices to support continuous quality improvement.

Additional DCYF staff training measures are outlined below:

- DCYF field workers received training on the Comprehensive Assessment for Treatment (CAT), which helps to determine level of care for a youth that may need residential treatment. This training, required for CPS and JJ, occurred throughout the month of September 2021.

- The Bureau of Children's Behavioral Health (BCBH) modules that rolled out from June through October 2021, provided an overview of the prevention services in place that are coordinated through BCBH and contracted providers.

- JJ received Child/Adolescent Needs & Strengths (CANS) assessment training during the month of October, and they also received training in Motivational Interviewing (MI) in the month of November. CPS will receive CANS and MI training as well, the date for CPS is anticipated to be late 2022, with CANS implementation occurring in early 2023.

- Prevention and Placement Case Planning training rolled out in September 2021 through CWEP and is required for all JJ and CPS field workers – this provides staff an intro to the new Prevention and Placement Case plans, as a result of the FFPSA legislation. It focuses

on DCYF policy regarding the Placement and Prevention and Case Plans, and the course will provide participants with the opportunity to view mock Placement and Prevention plans using case examples that are provided.

- Assessment workers for CPS will take CANS and MI in 2022, Assessment JPPOs will be trained in CANS and MI as those positions are filled for those specific roles, unless they are existing JPPOs – in which case they will have received both of those trainings in Oct/Nov as stated above. CANS and MI training will be required for all field workers, including Assessment.

- Assessment workers for both CPS and JJ are required to complete the CAT training as stated above, as well as Prevention and Placement Case Planning as stated above.

- Currently there are special trainings developed for current staff who complete prevention plans for child protection and juvenile justice involved children and families. These are provided for on-going staff in an online format with live Question and Answer sessions. The materials have been incorporated into the new staff training or Core training. Principles of Family First and prevention have been incorporated into case planning classes and additional classes related to community resources.

- NH is implementing the evidence-based assessment, the Child Adolescent Needs Strengths tool (CANS) in the juvenile justice service delivery system in 2022, and in the child protection system in 2023. To support that rollout, two days of Motivational Interviewing training, another evidence-based practice, will be offered for staff to gain the skills to most engage with the family and complete the assessment tool. This will be available to all current workforce and then incorporated into the Core training for new staff. Data from the CANS will be used to track need and use of community-based prevention services.

- CWEP has partnered with the Bureau of Children's Behavioral Health to provide training for all staff about prevention services and evidence-based services provided in New Hampshire. These trainings are currently being adapted for foster and adoptive parents as well as residential services caregivers to enhance their understanding of evidence-based services and opportunities for children in their care.

With the CBVS program already underway, statewide training has been completed. DCYF used town hall meetings to train direct practice staff, supervisors, and lawyers on CBVS. Six town halls were held remotely with consideration given to the schedules of the workforce. Two of the trainings focused on supervisors and lawyers, while the other four catered to front line staff. The town hall training focused primarily on the structure of CBVS services and how to identify and

refer candidates for CBVS. As additional evidence-based interventions in the service array are procured, the town hall style training format will be utilized to train the DCYF and CBVS workforce on the details of each practice and how to identify and refer candidates.

Required trainings about the specific EBP will be done by vendor as part of contracting for each service in collaboration with service array team staff. For example, the MST vendor will be providing training about the MST program to all levels of DCYF staff, including administration and direct care staff. The service array team, as part of their program and contract management, will be the subject matter experts from DCYF who are responsible for supporting, training and coaching DCYF staff in addition to the service provider.

Service Provider Workforce Training

The evidence-based practices included in this prevention plan were thoughtfully selected based on the effectiveness and replicability of its models. It is the expectation of DCYF that all providers of EBPs working with DCYF families will adhere to the staffing and training requirements specified by each EBP model.

The providers contracted to provide CBVS (with DCYF's financial and project management support) will train all CBVS staff including family engagement specialists and case management providers in Motivational Interviewing (MI). This training will allow them to fully integrate MI as a core component of the CBVS practice model. For example, MI will help CBVS workers better support families as they set goals within the child specific prevention plan, identify supports and services that could help them achieve those goals, and empower families to follow-through on those decisions. CBVS will also leverage MI to support service linkage and efforts to promote both the completion of CBVS and any supplemental supports and services they will receive. In some instances, those supplemental supports and services will be the EBPs that DCYF itself adds to the service array through Family First.

NH will work with the CBVS vendors to continue monitoring their training development and assist in coordinating the assurance that prevention plans are being developed and implemented. These prevention plans are to be ideally developed within the initial 30 days of the CBVS service and include both family and child level objectives. The workforce for both vendors participate in training for Solution Based Casework and Motivational Interviewing, which is inclusive of the IV-E claiming methods specifically focusing on the Motivational Interviewing structure.

CBVS Vendors MI staff training plan:

Vendor #1:

- Contracted with Health and Education Training Institute (HETI) to provide initial training to all CBVS staff, which was completed earlier in 2021. Any additionally hired staff will be trained as hired for the CBVS services.
- Contracted with Its Your Journey, LLC to provide booster trainings and practice reinforcement sessions, which were carried out in November 2021.
- Additionally, the vendor has adopted multiple strategies to reinforce and deepen MI practice among staff. The vendor purchased "Motivational Interviewing: Helping People Change" books, written by the founders of MI, William Miller and Stephen Rollnick and have asked their staff to review and read this book. Additionally, they have implemented a book club and a biweekly meeting entitled "MI Spirit Circle," where workers discuss the spirit of MI and where they can learn and practice skills together.
- The vendor has procured LYSSN, an artificial intelligence technology platform, to capture, rate and score their staff MI skills and fidelity to the MI model. Each worker will upload a minimum of two recordings weekly for scoring. Data from LYSSN will be used during supervision to explore staff strengths and areas needing improvement.
- Additionally, LYSSN is in the process of finalizing a customized internal training curriculum for provider staff. They have contracted with Dr. Theresa Moyers, a member of the Motivational Interviewing Network of Trainers (MINT) to create the training. Once initial training has been delivered, the vendor will partner with Dr. Moyers to provide MI ongoing training to staff on a regular basis.
- The training that LYSSN will do with Dr. Moyers, and the work with eSym are training resources that the vendor will have access to in the future, for when new staff is on boarded to provide initial training for Motivational Interviewing. HETI provided the initial cohort of training for the vendor's staff. The training provided by *It's Your Journey* dove a little deeper and provided the initial training for some staff that were brought on since the training with HETI. The vendor is not contracting with HETI moving forward for initial training. When LYSSN is up and running with their training system with this vendor, the vendor will work to determine what the best route is for initial training (i.e. eSym or LYSSN).
- In the meantime, (while LYSSN gets their training component finalized) the vendor is exploring options for an ongoing training curriculum through an organization called eSym. They have met with the founders of this organization and are working through a contract to work with them to provide ongoing training via an LMS model, integrating coaching sessions throughout the training, while also developing the ability to provide a much deeper dive into MI training for the vendor's supervisory team, so they can continue to support staff with their MI practice.

Vendor #2:

Level One – Trained in MI (Overview)

All Staff – All CBVS program staff (including direct care, supervisory and leadership level) receive a basic MI overview training with the agency's training coordinator within first 90 days of hire, introducing them to Fundamental Principles of MI and using the OARS (Open questions, affirmation, reflective listening, and summary reflections). Following training, staff will participate in no less than 4 peer coaching sessions to provide further practice.

Level Two – MI Student

- **Program Specific** – CBVS direct care program staff will receive the MI Basics Training (15 hours) with HETI and/or staff trainer within first 3 months of hire as part of a cohort (no more than 15 staff per cohort): 2 full days (5 hours each) of the basics of MI covering the 8 tasks of learning MI followed by 2 follow up days (2 weeks and 4 weeks after initial training, respectively) to review the fundamentals and allow for continued practice
- **Required Reading:** To deepen their understanding of MI practice, staff will be required to read through the materials in HETI's Compassion Reading Room, a library of literature on Motivational Interviewing and related topics. Ten articles can be found here: https://www.hetimaine.org/reading-room Workers will be required to complete a Family Resource Center (FRC) summary (form provided by vendor for staff) for each article and submit it to their supervisor and training coordinator.
- **Field Observation:** A recognized FRC MI Coach or Supervisor (trained to level 4) will conduct a field observation of the staff member using the FRC MI observation form and provide feedback to staff.
- **Coaching:** Staff will participate in weekly peer coaching sessions throughout this process; completing at least 10 additional hours of coaching

Level Three – FRC Recognized MI Certification

- **Prerequisite:** Staff must have completed MI basics training and logged at least 12 hours of coaching.
- **Observation & Response:** Staff will listen to a podcasts from Conversations in Compassion and submit their response worksheet to supervisor & training coordinator.
- **Recording:** Staff will submit biweekly recordings through HETI form or FRC MITI coding staff until they receive 3 "proficient" scores in a row. Staff will meet with MI trainer at least once to process coding scores and receive feedback.
- **Field Observation:** A recognized FRC MI Coach or Supervisor (trained to level 4) will conduct at least 3 additional field observations of the staff member using the FRC MI observation form and provide feedback to staff.

- **Continued Coaching –** Certified Staff will continue to participate in peer coaching sessions at least 1x per month

Level Four – MI Certified / Peer Coach

- **Prerequisite:** This level is for identified staff who embrace the spirit of MI and would like to continue to advance their practice as a peer coach. Staff must have completed MI basics and become "FRC certified" in MI to continue to this tier. Must have recommendation of MI Trainer/Coach and/or Training Coordinator. Must submit at least 3 "proficient" MITI recordings or field audits. Must be approved by supervisor **and** program manager.
- **Attend MI Advancing the Practice Training** – Through HETI and/or FRC staff trainer.
- **Recording***:* Staff will continue to submit monthly recordings to HETI and/or staff MITI coder to stay fresh and receive continued feedback on their practice.
- **Field Observation:** Staff will facilitate a group coaching session that will be observed by the MI Trainer/Coach or FRC MI Supervisor who will then provide feedback.
- **Coaching** – Staff will continue to participate in peer coaching sessions with Trainer/Master class monthly; Staff will offer peer coaching either in person or virtually to their "team" regularly based on program needs.
- Staff at this level will help to provide ongoing peer coaching to staff.

Level Five – FRC In-House Trainer - This level is for 1-3 identified staff who have proven proficiency and an understanding of the spirit of MI.

Healthy Families America (HFA) will be delivered through a partnership with the Department of Public Health (DPHS) and its contracted providers. DPHS follows the training requirements outlined in the HFA Best Practices Standards (Healthy Families America, 2018). To become an HFA provider site, Family Resource Specialists, Family Support Specialists and Supervisors receive role specific core training from an HFA certified trainer within the first six months of employment. In situations where the HFA specialist begins providing services to families prior to receiving core training, they must receive orientation and stop-gap training. All HFA staff have training prior to engaging in activities associated with their specific role, including supervision. Within six months of hire date the Family Resource Specialists engage in intensive HFA Core Assessment Training, HFA Family Support Specialists and their supervisors participate in HFA Core Integrated Strategies for Family Support Specialists and Supervisors attend HFA's Core Supervision Training. These trainings are designed to ensure each staff member understands the essential components of their role. HFA sites are encouraged to include shadowing experiences and for individual staff to pursue full HFA certification for their role. HFA updates training as

needed and require periodic refresher trainings. Training requirements are monitored as part of the HFA site accreditation process.

As stated previously, MST, Intercept, and Homebuilders will also be delivered by contracted private providers. As procurement and contracting commences for each of these EBPs, provider contracts will require that providers be trained/certified in their specific practices and use research-based nationally recognized curricula. Providers will be expected to utilize assessments or other appropriate tools with demonstrated effectiveness in reducing the need for out-of-home care. Documentation of EBP model training and certification is maintained by DCYF to be reviewed annually by contract monitors for fiscal and programmatic compliance.

Section 8: Prevention Caseloads *(pre-print section 7)*

Caseload size is an important factor when providing effective prevention services for children and families. In order to understand caseload ratios in New Hampshire, it is important to distinguish between services provided by the DCYF workforce and contracted provider agencies who provide in-home case management services and the evidence-based interventions.

Family First prevention services will be provided by DCYF Assessment, Family Service and Post-Adoption CPSWs, Juvenile Probation and Parole Officers (JPPO), and private, contracted providers. Table 7 below indicates the approximate caseload size for DCYF and providers who will manage prevention services cases. The private provider to case ratio will vary by EBP.

Table 7: Staff to Case Ratio by Subpopulation

Subpopulation Description	Staff to Case Ratio
Children of families during investigation who are deemed safe, moderate to high risk, no current court involvement, and referred to CBVS	1:13
Children served in-home with an open DCYF case, either voluntary or court involved	1:13
Pregnant and Parenting Youth In-Care	1:13
Children served with an open in-home juvenile justice case	1:15
Children in recently reunified families	1:13
Children in adoption families	Not specified

DCYF Supervisors, CPS Field Administrators and the Field Services Administrator receive monthly data reports that include number of protective assessments assigned per month, current number of open cases, number of children in those cases and other statistical data related to practice outcomes. These reports are routinely reviewed at DCYF Leadership meetings and used to manage business operations and practice at the local level. Since the reports are designed to report how workloads increase/decrease over time, the CPS Field Administrators use the data to conduct an individual analysis of each District Office's workload on a regular basis. This analysis includes a breakdown of the number of staff per office by position type and averages the total number of protective assessments and family service cases managed per worker during that time period. The Field Services Administrator reviews this information, and a comparative analysis is completed to determine which offices are carrying the highest to lowest average number of assessments and cases per worker statewide. These results are used to inform decisions related to staff assignments that may include position reassignment within an office, temporary assignment of catchment areas to another office, permanent transfer of a position to another office and if deemed necessary request to the DCYF Director to create new positions.

In addition, DCYF has continued to utilize the Workforce Capacity and Workforce Analysis Report for Child Protection and Juvenile Justice. This report not only provides an overview of the number of assessments, cases and families served, but also indicates current workforce capacity and considers field staff who may be in a CPSW or JPPO position, but do not maintain a current caseload due to being a new hire in training, out on extended leave, etc. This report provides a more real-time picture to DCYF Administration of current caseloads and allows there to be more a more responsive approach to addressing needs in the field. Caseloads of all staff listed in Table 6 are monitored through the Workforce Capacity and Workforce Analysis Report for Child Protection and Juvenile Justice referenced above.

Currently, DCYF has an amount of family service CPSW positions that would allow for an average of a combined 10-12 prevention and placement cases on a worker's caseload. With current staffing turnover, the average caseload is in the range of 12-14 cases per worker.

DCYF expects all providers of all EBPs to uphold the staffing and caseload requirements specified by each EBPs model. DCYF will hold all EBP service providers contractually accountable to implementing each intervention to fidelity, including requirements of staff to client ratios to ensure fidelity to the model.

Section 9: Assurance on Prevention Program Reporting *(pre-print section 8; Attachment I)*

Attachment I contains DCYF's assurance (CB-PI-18-09 Attachment I) that it will comply with all prevention program reporting requirements put forward by the Children's Bureau. At a minimum, DCYF will provide the following information for each child that receives Title IV-E prevention services:

- Basic demographic information (e.g., age, sex, race/Hispanic Latino ethnicity)
- The specific services provided to the child and/or family
- The date(s) that the specific service(s) were added to the prevention plan
- The total expenditures for each of the services provided to the child and/or family
- The first and last date of each service provided
- If the child was identified in a prevention plan as a "child who is a potential candidate for foster care:"
    - the child's placement status at the beginning, and at the end, of the 12-month period that begins on the date the child was identified as a "child who is a potential candidate for foster care" in a prevention plan
    - whether the child entered foster care during the initial 12-month period and during the subsequent 12-month period.

References

Asscher, J. J., Dekovic, M., Manders, W. A., van der Laan, P. H., & Prins, P. J. M. (2013). A randomized controlled trial of the effectiveness of Multisystemic Therapy in the Netherlands: Post-treatment changes and moderator effects. *Journal of Experimental Criminology, 9*(2), 169-187.

Asscher, J. J., Dekovic, M., Manders, W., van der Laan, P. H., Prins, P. J. M., van Arum, S., & Dutch MST Cost-Effectiveness Study Group. (2014). Sustainability of the effects of Multisystemic Therapy for juvenile delinquents in the Netherlands: Effects on delinquency and recidivism. *Journal of Experimental Criminology, 10*(2), 227-243.

Asscher, J. J., Dekovic, M., Van den Akker, A. L., Prins, P. J. M., & Van der Laan, P. H. (2018). Do extremely violent juveniles respond differently to treatment? *International Journal of Offender Therapy and Comparative Criminology, 62*(4), 958-977. doi:10.1177/0306624X16670951

Bair-Merritt, M. H., Jennings, J. M., Chen, R., Burrell, L., McFarlane, E., Fuddy, L., & Duggan, A. K. (2010). Reducing maternal intimate partner violence after the birth of a child: A randomized controlled trial of the Hawaii Healthy Start home visitation program. *Archives of Pediatrics & Adolescent Medicine, 164(*1), 16-23. doi:10.1001/archpediatrics.2009.237

Barlow, A., Varipatis-Baker, E., Speakman, K., Ginsburg, G., Friberg, I., Goklish, N., . . . Pan, W. (2006). Home-visiting intervention to improve child care among American Indian adolescent mothers: A randomized trial. Archives of Pediatrics & Adolescent Medicine, 160(11), 1101-1107.

Borduin, C. M., Henggeler, S. W., Blaske, D. M., & Stein, R. J. (1990). Multisystemic treatment of adolescent sexual offenders. *International Journal of Offender Therapy and Comparative Criminology, 34*(2), 105-113.

Borduin, C. M., Mann, B. J., Cone, L. T., Henggeler, S. W., Fucci, B. R., Blaske, D. M., & Williams, R. A. (1995). Multisystemic treatment of serious juvenile offenders: *Long-term prevention of criminality and violence. Journal of Consulting and Clinical Psychology, 63*(4), 569-578.

Butler, S., Baruch, G., Hickey, N., & Fonagy, P. (2011). A randomized controlled trial of Multisystemic Therapy and a statutory therapeutic intervention for young offenders. *Journal of the American Academy of Child & Adolescent Psychiatry, 50*(12), 1220-1235.e2. doi:https://doi.org/10.1016/j.jaac.2011.09.017

Caldera, D., Burrell, L., Rodriguez, K., Crowne, S. S., Rohde, C., & Duggan, A. (2007). Impact of a statewide home visiting program on parenting and on child health and development. *Child Abuse & Neglect, 31*(8), 829-852. doi:http://dx.doi.org/10.1016/j.chiabu.2007.02.008

Carey, K. B., Carey, M. P., Maisto, S. A., & Henson, J. M. (2006). Brief motivational interventions for heavy college drinkers: A randomized control trial. *Journal of Consulting and Clinical Psychology, 74(*5), 943-954. doi: 10.1037/0022-006X.74.5.943

Carroll, K. M., Libby, B., Sheehan, J., & Hyland, N. (2001). Motivational interviewing to enhance treatment initiation in substance abusers: an effectiveness study. *The American Journal on Addictions*, *10*(4), 335-339.

Cary, M., Butler, S., Baruch, G., Hickey, N., & Byford, S. (2013). Economic evaluation of Multisystemic Therapy for young people at risk for continuing criminal activity in the UK. *PLoS ONE, 8*(4), e61070-e61070. doi:10.1371/journal.pone.0061070.

Casey Family Programs. (2020). *How is New Hampshire Building a 21st Century Child Strengthening and Family Well-Being System?* Retrieved from: https://www.casey.org/chris-tappan-qa/

Center for Creative Leadership (2016). *Boundary Spanning Leadership Mission Critical Perspectives from the Executive Suite.* Retrieved on 4/24/2020 from https://cclinnovation.org/wp-content/uploads/2020/02/boundaryspanningleadership.pdf.

Center for Program Design and Evaluation at Dartmouth. (2018). *Then & now: perspective from New Hampshire's foster and adoptive families 2015-2018*. Presented to NH DCYF Leadership. Powerpoint Presentation.

Center for Support of Families. (2016). *Quality Assurance Review of the Division of Children and Family Services.* Retrieved from: https://www.dhhs.nh.gov/dcyf/documents/csf-qa-review-report.pdf

Center for the Study of Social Policy (2018). *About Strengthening Families and the Protective Factors Framework*. Retrieved on 4/25/21 from: https://cssp.org/wp-content/uploads/2018/11/About-Strengthening-Families.pdf

Chaffin, M., Funderburk, B., Bard, D., Valle, L. A., & Gurwitch, R. (2011). A combined motivation and parent–child interaction therapy package reduces child welfare recidivism in a randomized dismantling field trial. *Journal of consulting and clinical psychology*, *79*(1), 84.

Chaffin, M., Valle, L. A., Funderburk, B., Gurwitch, R., Silovsky, J., Bard, D., ... & Kees, M. (2009). A motivational intervention can improve retention in PCIT for low-motivation child welfare clients. *Child maltreatment*, *14*(4), 356-368.

Cluxton-Keller, F., Burrell, L., Crowne, S. S., McFarlane, E., Tandon, S. D., Leaf, P. J., & Duggan, A. K. (2014). Maternal relationship insecurity and depressive symptoms as moderators of home visiting impacts on child outcomes. Journal of Child and Family Studies, 23(8), 1430-1443. doi:http://dx.doi.org/10.1007/s10826-013-9799-x.

Dekovic, M., Asscher, J. J., Manders, W. A., Prins, P. J. M., & van der Laan, P. (2012). Within-intervention change: Mediators of intervention effects during Multisystemic Therapy. *Journal of Consulting and Clinical Psychology, 80(*4), 574-587.

Diaz Gomez, C., Ngantcha, M., Le Garjean, N., Brouard, N., Lasbleiz, M., Perennes, M., . . . Bellou, A. (2019). Effect of a brief motivational intervention in reducing alcohol consumption in the emergency department: A randomized controlled trial. *European Journal Of Emergency Medicine, 26(*1), 59-64. doi:10.1097/MEJ.0000000000000488

Dopp, A. R., Borduin, C. M., Wagner, D. V., & Sawyer, A. M. (2014). The economic impact of Multisystemic Therapy through midlife: A costbenefit analysis with serious juvenile offenders and their siblings. *Journal of Consulting and Clinical Psychology, 82*(4), 694-705. doi:http://dx.doi.org/10.1037/a0036415

Dopp, A. R., Borduin, C. M., Willroth, E. C., & Sorg, A. A. (2017). Long-term economic benefits of psychological interventions for criminality: Comparing and integrating estimation methods. *Psychology, Public Policy, and Law, 23*(3), 312-323. doi:http://dx.doi.org/10.1037/law0000134

Duggan, A. K., Berlin, L. J., Cassidy, J., Burrell, L., & Tandon, S. D. (2009). Examining maternal depression and attachment insecurity as moderators of the impacts of home visiting for at-risk mothers and infants. Journal of Consulting and Clinical Psychology, 77(4), 788-799. doi:http://dx.doi.org/10.1037/a0015709 El-Kamary, S. S., Higman, S. M., Fuddy, L., McFarlane, E., Sia, C., & Duggan, A. K. (2004). Hawaii's Healthy Start home visiting program: Determinants and impact of rapid repeat birth. Pediatrics, 114(3), e317-326.

Duggan, A., Caldera, D., Rodriguez, K., Burrell, L., Rohde, C., & Crowne, S. S. (2007). Impact of a statewide home visiting program to prevent child abuse. *Child Abuse & Neglect, 31*(8), 801-827.

Duggan, A., Caldera, D. Rodriguez, K., Burrell, L., Shea, S., & Rohde, C. (2005). Evaluation of the Healthy Families Alaska program: Final report. Juneau, AK: Alaska State Department of Health and Social Services.

Duggan, A., Fuddy, L., Burrell, L., Higman, S. M., McFarlane, E., Windham, A., & Sia, C. (2004). Randomized trial of a statewide home visiting program to prevent child abuse: Impact in reducing parental risk factors. Child Abuse & Neglect, 28(6), 623-643. doi:http://dx.doi.org/10.1016/j.chiabu.2003.08.008

Duggan, A. K., McFarlane, E. C., Windham, A. M., Rohde, C. A., Salkever, D. S., Fuddy, L., . . . Sia, C. C. J. (1999). Evaluation of Hawaii's Healthy Start program. *Future of Children, 9*(1), 66-90.

Duggan, A., McFarlane, E., Fuddy, L., Burrell, L., Higman, S. M., Windham, A., & Sia, C. (2004). Randomized trial of a statewide home visiting program to prevent child abuse: Impact in preventing child abuse and neglect. *Child Abuse & Neglect, 28(*6), 597-622.

DuMont, K., Kirkland, K., Mitchell-Herzfeld, S., Ehrhard-Dietzel, S., Rodriguez, M. L., Lee, E., ... & Greene, R. (2010).A randomized trial of Healthy Families New York (HFNY): Does home visiting prevent child maltreatment? Rensselaer, NY: New York State Office of Children & Family Services and Albany, NY: University of Albany, State University of New York.

DuMont, K., Mitchell-Herzfeld, S., Greene, R., Lee, E., Lowenfels, A., Rodriguez, M., & Dorabawila, V. (2008). Healthy Families New York (HFNY) randomized trial: Effects on early child abuse and neglect. *Child Abuse & Neglect, 32*(3), 295-315.

Easterbrooks, M. A., Kotake, C., & Fauth, R. (2019). Recurrence of maltreatment after newborn home visiting: A randomized control trial. American Journal of Public Health. (Online Advance). doi:10.2105/AJPH.2019.304957

Fernandez, A. C., Waller, R., Walton, M. A., Bonar, E. E., Ignacio, R. V., Chermack, S. T., . . . Blow, F. C. (2019). Alcohol use severity and age moderate the effects of brief interventions in an emergency department randomized controlled trial. *Drug & Alcohol Dependence*, 194, 386-394. doi:10.1016/j.drugalcdep.2018.10.021

Field, C., Caetano, R. (2010). The role of ethnic matching between patient and provider on the effectiveness of brief alcohol interventions with hispanics. *Alcoholism, 34*(2), 262-271. doi:http://dx.doi.org/10.1111/j.1530-0277.2009.01089.x

Field, C., Walters, S., Marti, C. N., Jun, J., Foreman, M., & Brown, C. (2014). A multisite randomized controlled trial of brief intervention to reduce drinking in the trauma care setting: How brief is brief? *Annals Of Surgery, 259*(5), 873-880. doi:10.1097/SLA.0000000000000339

Fonagy, P., Butler, S., Cottrell, D., Scott, S., Pilling, S., Eisler, I., . . . Goodyer, I. M. (2018). Multisystemic Therapy versus management as usual in the treatment of adolescent antisocial behaviour (START): A pragmatic, randomised controlled, superiority trial. *The Lancet. Psychiatry, 5(*2), 119-133. doi:10.1016/S2215-0366(18)30001-4

Fonagy, P., Butler, S., Goodyer, I., Cottrell, D., Scott, S., Pilling, S., . . . Haley, R. (2013). Evaluation of Multisystemic Therapy pilot services in the Systemic Therapy for At Risk Teens (START) trial: Study protocol for a randomised controlled trial. *Trials, 14*(1), 1-9. doi:10.1186/1745-6215-14-265.

Forrester, D., McCambridge, J., Waissbein, C., Emlyn-Jones, R., & Rollnick, S. (2008). Child risk and parental resistance: Can motivational interviewing improve the practice of child and family social workers in working with parental alcohol misuse?. *British Journal of Social Work, 38*(7), 1302-1319.

Forrester, D., Westlake, D., Killian, M., Antonopoulou, V., McCann, M., Thurnham, A., ... & Hutchison, D. (2018). A randomized controlled trial of training in Motivational Interviewing for child protection. *Children and Youth Services Review*, *88*, 180-190.

Freyer-Adam, J., Coder, B., Baumeister, S. E., Bischof, G., Riedel, J., Paatsch, K., . . . Hapke, U. (2008). Brief alcohol intervention for general hospital inpatients: A randomized controlled trial. *Drug and Alcohol Dependence, 93*(3), 233-243. doi:http://dx.doi.org/10.1016/j.drugalcdep.2007.09.016

Fuster, D., Cheng, D. M., Wang, N., Bernstein, J. A., Palfai, T. P., Alford, D. P., . . . Saitz, R. (2016). Brief intervention for daily marijuana users identified by screening in primary care: A subgroup analysis of the aspire randomized clinical trial. *Substance Abuse, 37*(2), 336-342. doi:http://dx.doi.org/10.1080/08897077.2015.1075932

Gaume, J., Gmel, G., Faouzi, M., Bertholet, N., & Daeppen, J. B. (2011). Is brief motivational intervention effective in reducing alcohol use among young men voluntarily receiving it? A randomized controlled trial. *Alcoholism, 35*(10), 1822-1830. doi: 10.1111/j.1530-0277.2011.01526.x

Gentilello, L. M., Rivara, F. P., Donovan, D. M., Jurkovich, G. J., Daranciang, E., Dunn, C. W., . . . Ries, R. R. (1999). Alcohol interventions in a trauma center as a means of reducing the risk of injury recurrence. *Annals Of Surgery, 230*(4), 473-480.

Goldsmith, T. (Ed.). (2007). *Youth Villages clinical protocols treatment manual*. Youth Villages.

Green, B. L., Tarte, J. M., Harrison, P. M., Nygren, M., & Sanders, M. B. (2014). Results from a randomized trial of the Healthy Families Oregon accredited statewide program: Early program impacts on parenting. *Children and Youth Services Review*, 44, 288-298.

Green, B., Sanders, M. B., & Tarte, J. M. (2018). Effects of home visiting program implementation on preventive health care access and utilization: Results from a randomized trial of Healthy Families Oregon. Prevention Science. (Online Advance) https://doi.org/10.1007/s11121-018-0964-8.

Hall, M. T., Sears, J., & Walton, M. T. (2020). Motivational interviewing in child welfare services: a systematic review. *Child maltreatment*, *25*(3), 263-276.

Hansen, A. B. G., Becker, U., Nielsen, A. S., Grønbæk, M., & Tolstrup, J. S. (2012). Brief alcohol intervention by newly trained workers versus leaflets: Comparison of effect in older heavy drinkers identified in a population health examination survey: A randomized controlled trial. *Alcohol and Alcoholism, 47*(1), 25-32. doi: 10.1093/alcalc/agr140

Healthy Families America. (2017). *HFA Best Practice Standards.* Prevent Child Abuse America. Retrieved on 11/17/2020 from: https://www.dhs.state.il.us/OneNetLibrary/27896/documents/GATA_2020Grants/FCS/OtherDocuments/2018_2021HFABestPracticeStandardsJuly2017_.pdf

Healthy Families America (2018). *Healthy Families America Child Welfare Adaptation*. Retrieved on 6/27/20 from: https://oregonearlylearning.com/wp-content/uploads/2018/09/HFA-Child-Welfare-Adaptation.pdf

Henggeler, S. W., Borduin, C. M., Melton, G. B., Mann, B. J., Smith, L. A., Hall, J. A., & Fucci, B. R. (1991). Effects of Multisystemic Therapy on drug use and abuse in serious juvenile offenders: A progress report from two outcome studies. *Family Dynamics of Addiction Quarterly*, 1, 40-51.

Henggeler, S. W., Halliday-Boykins, C. A., Cunningham, P. B., Randall, J., Shapiro, S. B., & Chapman, J. E. (2006). Juvenile drug court: Enhancing outcomes by integrating evidence-based treatments. *Journal of Consulting and Clinical Psychology, 74*(1), 42-54.

Henggeler, S. W., Melton, G. B., Brondino, M. J., Scherer, D. G., & Hanley, J. H. (1997). Multisystemic Therapy with violent and chronic juvenile offenders and their families: The role of treatment fidelity in successful dissemination. Journal of Consulting and Clinical Psychology, 65(5), 821-833.

Henggeler, S. W., Melton, G. B., & Smith, L. A. (1992). Family preservation using Multisystemic Therapy: An effective alternative to incarcerating serious juvenile offenders. *Journal of Consulting and Clinical Psychology, 60(*6), 953-961.

Henggeler, S. W., Melton, G. B., Smith, L. A., Schoenwald, S. K., & Hanley, J. H. (1993). Family preservation using multisystemic treatment: Long-term follow-up to a clinical trial with serious juvenile offenders. *Journal of Child and Family Studies, 2*(4), 283-293.

Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). *Multisystemic Therapy for antisocial behavior in children and adolescents* (2nd ed.). Guilford Press.

Huhr, S., & Wulczyn, F. (2020a). Do intensive in-home services prevent placement?: A case study of Youth Villages' Intercept® program. The Center for State Child Welfare Data.

Huhr, S., & Wulczyn, F. (2020b). Do intensive in-home services promote permanency?: A case study of Youth Villages' Intercept® program. The Center for State Child Welfare Data.

Huhr, S., & Wulczyn, F. (2021). The impact of Youth Villages' Intercept program on placement prevention: A second look. The Center for State Child Welfare Data.

Institute for Family Development, (2014) HOMEBUILDERS® Fidelity Measures

Jansen, D. E. M. C., Vermeulen, K. M., Schuurman-Luinge, A. H., Knorth, E. J., Buskens, E., & Reijneveld, S. A. (2013). Cost-effectiveness of Multisystemic Therapy for adolescents with antisocial behaviour: Study protocol of a randomized controlled trial. *BMC Public Health*, 13, 369-369. doi:10.1186/1471-2458-13-369

Johnides, B. D., Borduin, C. M., Wagner, D. V., & Dopp, A. R. (2017). Effects of Multisystemic Therapy on caregivers of serious juvenile offenders: A 20-year follow-up to a randomized clinical trial. *Journal of Consulting and Clinical Psychology, 85*(4), 323-334. doi:10.1037/ccp0000199

Kelly, J., Tiano, S., Loudenback, J., reports, T. I. staff, & DiLorenzo, P. S. (2021, February 17). *Michigan funds homebuilders model in preparation for Family first act*. The Imprint. Retrieved November 23, 2021, from https://imprintnews.org/youth-services-insider/michigan-funds-homebuilders-model-in-preparation-for-family-first-act/51975.

Kirkland, K., & Mitchell-Herzfeld, S. (2012). Evaluating the effectiveness of home visiting services in promoting children's adjustment in school. Washington, DC: The Pew Charitable Trusts.

Kistenmacher, B. R., & Weiss, R. L. (2008). *Motivational Interviewing as a mechanism for change in men who batter: A randomized controlled trial*. Violence and Victims, *23*(5), 558-570.

Klietz, S. J., Borduin, C. M., & Schaeffer, C. M. (2010). Cost-benefit analysis of Multisystemic Therapy with serious and violent juvenile offenders. *Journal Of Family Psychology, 24*(5), 657-666. doi:10.1037/a0020838

Landsverk, J., Carrilio, T., Connelly, C. D., Ganger, W., Slymen, D., Newton, R., et al. (2002). Healthy Families San Diego clinical trial: Technical report. San Diego, CA: The Stuart Foundation, California Wellness Foundation, State of California Department of Social Services: Office of Child Abuse Prevention.

LeCroy, C. W., & Krysik, J. (2011). Randomized trial of the Healthy Families Arizona home visiting program. *Children and Youth Services Review, 33*(10), 1761-1766.

Lee, E., Kirkland, K., Miranda-Julian, C., & Greene, R. (2018). Reducing maltreatment recurrence through home visitation: A promising intervention for child welfare involved families. Child Abuse & Neglect, 86, 55-66. doi:http://dx.doi.org/10.1016/j.chiabu.2018.09.004.

Manders, W. A., Dekovic, M., Asscher, J. J., van der Laan, P. H., & Prins, P. J. M. (2013). Psychopathy as predictor and moderator of Multisystemic Therapy outcomes among adolescents treated for antisocial behavior. *Journal of Abnormal Child Psychology, 41*(7), 1121-1132.

Mann, B. J., Borduin, C. M., Henggeler, S. W., & Blaske, D. M. (1990). An investigation of systemic conceptualizations of parent-child coalitions and symptom change. *Journal of Consulting and Clinical Psychology, 58(*3), 336-344. doi:http://dx.doi.org/10.1037/0022-006X.58.3.336

Manuel, J.K. & Drapkin, M.L. (2014) Department of Veteran's Affairs Motivational Interviewing and Motivational Enhancement Training Programs Presented at the Motivational Interviewing Network of Trainers Forum Atlanta, Georgia October 7–8, 2014.

Marlatt, G. A., Baer, J. S., Kivlahan, D. R., Dimeff, L. A., Larimer, M. E., Quigley, L. A., . . . Williams, E. (1998). Screening and brief intervention for high-risk college student drinkers: Results from a 2-year follow-up assessment. *Journal of Consulting and Clinical Psychology, 66*(4), 604-615. doi:10.1037/0022-006X.66.4.604

McFarlane, E., Burrell, L., Crowne, S., Cluxton-Keller, F., Fuddy, L., Leaf, P., & Duggan, A. (2013). Maternal relationship security as a moderator of home visiting impacts on maternal psychosocial functioning. *Prevention Science, 14*(1), 25-39.

Miller, W. R., & Rollnick, S. (2012). *Motivational interviewing: Helping people change.* New York, NY. Guilford press.

Mitchell-Herzfeld, S., Izzo, C., Greene, R., Lee, E., & Lowenfels, A. (2005). Evaluation of Healthy Families New York (HFNY): First year program impacts. Albany, NY: University at Albany, Center for Human Services Research.

Moyers, T. B., Martin, T., Manuel, J. K., Hendrickson, S. M., & Miller, W. R. (2005). Assessing competence in the use of motivational interviewing. *Journal of substance abuse treatment, 28*(1), 19-26.

Multisytemic Therapy Services, Inc. (2020). MST Quality Assurance Program. Retrieved on 6/27/20 from: https://www.msti.org/mstinstitute/qa_program/

New Hampshire Children's Trust. (n.d.) *Family Support New Hampshire: Family Resource Centers.* Retrieved from https://48eb1361-1c4e-4223-93cd-676c4536510e.filesusr.com/ugd/38c037_86fad806cb01491bbe57204c51c3a1d6.pdf

New Hampshire Children's Trust. (n.d.) *Family Support New Hampshire: Kinship Navigation Program.* Retrieved from https://48eb1361-1c4e-4223-93cd-676c4536510e.filesusr.com/ugd/38c037_5d074d880a034371bd088287f671c2d5.pdf

New Hampshire Department of Health and Human Services (2020a). New Hampshire Department of Health and Human Services, Division for Children, Youth and Families 2020 Data Book. Retrieved from: https://www.dhhs.nh.gov/dcyf/documents/dcyf-data-book-2020.pdf

New Hampshire Department of Health and Human Services. (2020b). Community-Based Voluntary Services RFP. Retrieved from: https://www.dhhs.nh.gov/business/rfp/documents/rfp-2021-dcyf-03-commu.pdf

New Hampshire Department of Health and Human Services. (2020c). *NH DCYF Strategic Priorities SFY 20 & 21*.

New Hampshire Division of Children, Youth & Families (2020). *Summary and detail of Preservation - Reunification - MST focus groups - as of 090320 - V1* document. Unpublished internal agency document.

New Hampshire Office of the Child Advocate (2019). *New Hampshire Office of the Child Advocate System Review 2018-01 – Enhanced Response to Substance Exposed Infants.* Retrieved from: https://childadvocate.nh.gov/documents/reports/OCA-SR-Subs-Exp-Infants-11-22-19.pdf

Ogden, T., & Hagen, K. A. (2006). Multisystemic treatment of serious behavior problems in youth: Sustainability of effectiveness two years after intake. *Child and Adolescent Mental Health, 11*(3), 142-149.

Ogden, T., & Hagen, K. A. (2009). What works for whom? Gender differences in intake characteristics and treatment outcomes following Multisystemic Therapy. *Journal of Adolescence, 32*(6), 1425-1435.

Ogden, T., & Halliday-Boykins, C. A. (2004). Multisystemic treatment of antisocial adolescents in Norway: Replication of clinical outcomes outside of the US. *Child and Adolescent Mental Health, 9*(2), 77-83. doi:doi:10.1111/j.1475-3588.2004.00085.x

Porter, B., & Howe, T. (2008). Pilot evaluation of the "ACT parents raising safe kids" violence prevention program. *Journal of Child & Adolescent Trauma*, *1*(3), 193-206.

Predict Align Prevent (2021). Predict, Align, Prevent – Resources. Retrieved on 4/25/2021 from https://www.predict-align-prevent.org/resources.

Program Structure Standards. Kinney, J., Haapala, D. A., & Booth, C. (1991). Keeping Families Together: The HOMEBUILDERS Model. New York, NY: Taylor Francis. Retrieved on 3/6/2021 from: https://www.taylorfrancis.com/books/keeping-families-together-jill-kinney-david-haapala-charlotte-booth/10.4324/9780203787786

Public Consulting Group. (2018). *New Hampshire Children and Family Services Adequacy and Enhancement Assessment.* Retrieved from: https://www.dhhs.nh.gov/dcyf/documents/adequacy-enhance-assess-070318.pdf

Rendall-Mkosi, K., Morojele, N., London, L., Moodley, S., Singh, C., & Girdler-Brown, B. (2013). A randomized controlled trial of motivational interviewing to prevent risk for an alcohol-exposed pregnancy in the Western Cape, South Africa. *Addiction, 108*(4), 725-732. doi:http://dx.doi.org/10.1111/add.12081

Rodriguez, M. L., Dumont, K., Mitchell-Herzfeld, S. D., Walden, N. J., & Greene, R. (2010). Effects of Healthy Families New York on the promotion of maternal parenting competencies and the prevention of harsh parenting. Child Abuse & Neglect, 34(10), 711-723. doi:http://dx.doi.org/10.1016/j.chiabu.2010.03.004.

Roy-Byrne, P., Bumgardner, K., Krupski, A., Dunn, C., Ries, R., Donovan, D., . . . Zarkin, G. A. (2014). Brief intervention for problem drug use in safety-net primary care settings: A randomized clinical trial. *JAMA, 312*(5), 492-501. doi:http://dx.doi.org/10.1001/jama.2014.7860

Runyon, M. K., Deblinger, E., & Schroeder, C. M. (2009). Pilot evaluation of outcomes of combined parent-child cognitive-behavioral group therapy for families at risk for child physical abuse. *Cognitive and Behavioral Practice*, *16*(1), 101-118.

Saitz, R., Palfai, T. P. A., Cheng, D. M., Alford, D. P., Bernstein, J. A., Lloyd-Travaglini, C. A., . . . Samet, J. H. (2014). Screening and brief intervention for drug use in primary care: The ASPIRE randomized clinical trial. *JAMA, 312*(5), 502-513. doi:http://dx.doi.org/10.1001/jama.2014.7862

Saitz, R., Palfai, T. P., Cheng, D. M., Horton, N. J., Freedner, N., Dukes, K., . . . Samet, J. H. (2007). Brief intervention for medical inpatients with unhealthy alcohol use: A randomized, controlled trial. *Annals Of Internal Medicine, 146*(3), 167-176. doi:10.7326/0003-4819-146-3-200702060-00005.

Sakai, C., Lin, H., & Flores, G. (2011). Health outcomes and family services in kinship care: Analysis of a national sample of children in the child welfare system. *Archives of Pediatrics & Adolescent Medicine, 165*(2), 159–165.

Sawyer, A. M., & Borduin, C. M. (2011). Effects of Multisystemic Therapy through midlife: A 21.9-year follow-up to a randomized clinical trial with serious and violent juvenile offenders. *Journal of Consulting and Clinical Psychology, 79*(5), 643-652.

Schaeffer, C. M., & Borduin, C. M. (2005). Long-term follow-up to a randomized clinical trial of Multisystemic Therapy with serious and violent juvenile offenders. *Journal of Consulting and Clinical Psychology, 73(*3), 445-453. https://doi.org/10.1037/0022-006X.73.3.445

Schaeffer, C. M., Swenson, C. C., Tuerk, E. H., & Henggeler, S. W. (2013). Comprehensive treatment for co-occurring child maltreatment and parental substance abuse: Outcomes from a 24-month pilot study of the MST-Building Stronger Families program. *Child Abuse & Neglect*, *37*(8), 596-607.

Scherer, D. G., Brondino, M. J., Henggeler, S. W., Melton, G. B., & Hanley, J. H. (1994). Multisystemic Family Preservation Therapy: Preliminary findings from a study of rural and minority serious adolescent offenders. *Journal of Emotional and Behavioral Disorders, 2*(4), 198-206. doi:http://dx.doi.org/10.1177/106342669400200402

Shah, A., Jeffries, S., Cheatham, L. P., Hasenbein, W., Creel, M., Nelson-Gardell, D., & White-Chapman, N. (2019). Partnering With Parents: Reviewing the Evidence for Motivational Interviewing in Child Welfare. *Families in Society, 100(*1), 52-67.

Song, D., Xu, T. Z., & Sun, Q. H. (2014). Effect of motivational interviewing on self-management in patients with type 2 diabetes mellitus: A meta-analysis. *International Journal of Nursing Sciences*, *1*(3), 291-297.

Title IV-E Prevention Services Clearinghouse. Intercept. https://preventionservices.abtsites.com/programs/331/show

Title IV-E Prevention Services Clearinghouse. Intercept. Summary of Findings. https://preventionservices.abtsites.com/programs/331/show

Vermeulen, K. M., Jansen, D. E. M. C., Knorth, E. J., Buskens, E., & Reijneveld, S. A. (2017). Cost?effectiveness of Multisystemic Therapy versus usual treatment for young people with antisocial problems. *Criminal Behaviour and Mental Health, 27*(1), 89-102. doi:http://dx.doi.org/10.1002/cbm.1988

Vidal, S., Steeger, C. M., Caron, C., Lasher, L., & Connell, C. M. (2017). Placement and delinquency outcomes among system-involved youth referred to Multisystemic Therapy: A propensity score matching analysis. *Administration and Policy in Mental Health and Mental Health Services Research, 44*(6), 853-866. doi:10.1111/1745-9133.12064

Wagner, D. V., Borduin, C. M., Sawyer, A. M., & Dopp, A. R. (2014). Long-term prevention of criminality in siblings of serious and violent juvenile offenders: A 25-year follow-up to a randomized clinical trial of Multisystemic Therapy. *Journal of Consulting and Clinical Psychology, 82*(3), 492-499.

Walton, E. (1998). In-home family-focused reunification: A six-year follow-up of a successful experiment. *Social Work Research, 22*(4), 205-214. doi:10.1093/swr/22.4.205

Walton, E., Fraser, M. W., Lewis, R. E., & Pecora, P. J. (1993). In-home family-focused reunification: An experimental study. *Child Welfare, 72*(5), 473-487.

Weiss, B., Han, S. S., Harris, V., Catron, T., Ngo, V. K., Caron, A., . . . Guth, C. (2013). An independent randomized clinical trial of Multisystemic Therapy with non-court-referred adolescents with serious conduct problems. *Journal of Consulting and Clinical Psychology, 81*(6), 1027-1039. doi:10.1037/a0033928

Weiss, B., Han, S. S., Tran, N. T., Gallop, R., & Ngo, V. K. (2015). Test of facilitation vs. proximal process moderator models for the effects of Multisystemic Therapy on adolescents with severe conduct problem. *Journal of Abnormal Child Psychology, 43*(5), 971-983. doi:619722141; 2001-95012-326.

Westat, Chapin Hall Center for Children, & James Bell Associates. (2002). Evaluation of Family Preservation and Reunification Programs: Final Report. Washington, DC: U.S. Department of Health and Human Services.

Witte, S., Fegert, J., Walpert, S. (2018). Risk of maltreatment for siblings: Factors associated with similar and different childhood experiences in a dyadic sample of adult siblings. *Child Abuse & Neglect*, 76, 321-333.

Wulczyn, F., Parolini, A., Schmits, F., Magruder, J., & Webster, D. (2020). *Returning to foster care: Age and other risk factors*. Children and Youth Services Review, 116, 105166. doi:10.1016/j.childyouth.2020.105166

Appendix A: DCYF Family First Governance Structure

Workgroup	Description
Case Planning	DCYF staff field staff (both JJ & CPS), administrators and supervisors, policy, program specialists, BCBH, fiscal/provider relations & IT/Bridges staff meet bi-weekly to develop the revised case plan that will serve as the prevention plan to include Family First and candidacy requirements. This group is also responsible for defining recommendations for inclusion and workflow of the prevention plan in the future CCWIS system.
Technology	DCYF provider relations, program specialists, MMIS, DoIT, fiscal, BCBH and policy team representatives are creating SACWIS/CCWIS business requirements such as new screening, assessment, prevention planning and referral processes. Breakout groups meet to review fiscal, reporting and feeds to the Medicaid system (MMIS).
Service Array	Comprised of DCYF field staff, supervisors, a field administrator; Government Performance Lab colleagues, Policy Team, Provider Relations, Bureau of Organizational Learning and Quality Improvement (BOLQI), Bureau of Family support staff other DCYF positions (program specialists and Bridges). This group works to understand the specific targeted needs of each candidacy group and procure evidence-based services to meet the needs. Current focus is on creating an implementation strategy for CBVS. Team will also create trainings and service matching policy.
Assessment – SDM	Evident Change is rewriting the NH SDM tools for Intake, Assessment & Family Service. Steering committee includes administrators, field staff, supervisors, Policy, BOLQI and Bridges representatives in addition to CWEP (Child Welfare Educational Partnership through Granite State College). Group is led by the Evident Change (Formerly known as National Council on Crime & Delinquency). A validation study has been done and they will rewrite the SDM manual.
Assessment - CANS	Collaboration between BCBH and DCYF to coordinate the implementation of the CANS tool with both Juvenile Justice and CPS candidacy sub populations.

Fiscal	Breakout meetings comprised of Fiscal, Provider Relations, and Bridges Systems Analyst for IV-E claiming and coordination with Bridges system modifications.
Therapeutic foster care	A team comprised of BCBH, DoIT and DCYF members (FA, policy, program specialists, Bridges, etc.) including input from non-profit partners. The team is working to implement TFC to aid overall system transformation. The goal is to provide an alternative for kids who are unable to thrive in a traditional foster care setting. Steering committee will contract for TFC as a middle option between congregate care and traditional foster care.
Communications	Beginning in October 2020, this future team will work with community collaborators and the DHHS Public Information Office to create internal and external messaging regarding DCYF system transformation.
Court	DCYF General Counsel and Director of Legal Services are working on changes to court orders related to Family First (court approval of CAT assessment for QRTP placements). Also drafting legislation needed to support the future Family First process to claim IV-E for congregate care. Judges were trained in December 2020.